APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
Cigna Health and Life Insurance Company

PO Box 5725, Scranton, PA 18505-5725 • (866) 459-4272

Application is for: ☐ New business ☐ Reinstatement

Requested Medicare Supplement effective date* _____ Phone verification case # _____

**note: if no effective date is requested, we will assign the 1st day of the month following the date of this application*

Section I. Applicant Information

First name	MI	Last name	Age	Date of birth (MM/DD/YYYY)	State of birth

Resident street address *(no PO Box)* _____

City _____ State _____ ZIP _____

Mailing address *(if different from above)* _____

City _____ State _____ ZIP _____

Phone (_____) _____ **Email address** _____

Social Security No. (XXX-XX-XXXX)	Medicare card no.	Sex (M/F)	Household discount*
			☐ Yes ☐ No

Have you used tobacco within the last 12 months? ☐ Yes ☐ No **Rate class:** ☐ Preferred ☐ Standard

**If another member of your household is applying for or currently has a Medicare Supplement plan with Cigna Health and Life Insurance Company or an affiliated company, you may qualify for a household discount; see the Outline of Coverage for details. Please provide the name and Social Security Number (SSN) of the individual(s) living at your current address.*

Spouse/household member name

First name	MI	Last name	Spouse/household member SSN (XXX-XX-XXXX)

Section II. Coverage Applied for

Check plan selected: ☐ Plan A ☐ Plan F ☐ Plan High-Deductible F ☐ Plan G ☐ Plan N

Section III. Billing

Method *(select one of the following)*:
- ☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*
- ☐ Direct bill

Mode *(select one of the following)*:
- ☐ Monthly *(not available with* Direct bill*)*
- ☐ Quarterly
- ☐ Semi-annually
- ☐ Annually

Section IV. Billing Totals

Initial premium: ☐ Draft bank account ☐ Check enclosed *(payable to* **Cigna Health and Life Insurance Company***)*

Modal premium *(if household discount, then multiply modal premium by 0.93)* $_____

Total modal premium *(with discount(s) if applicable)* $_____

Total premium with application $_____

Section V. Open Enrollment / Guaranteed Issue Questions (MUST BE COMPLETED)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for Guaranteed Issue of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS *(mark* **YES** *or* **NO** *below with an "X")*.

To the best of your knowledge:	YES	NO
1. a. Did you turn age 65 in the last six (6) months?	☐	☐
b. Did you enroll in Medicare Part B in the last six (6) months?	☐	☐
If YES, what is the effective date? _____		
2. Are you covered for medical assistance through the state Medicaid program? (Note to Applicant: if you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)	☐	☐
If YES,		
a. will Medicaid pay your premiums for this Medicare Supplement policy?	☐	☐
b. do you receive any benefits from Medicaid ***other than*** payments toward your Medicare Part B premium?	☐	☐
3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?	☐	☐
If YES,		
a. fill in your START and END dates below *(if you are still covered under this plan, leave the* END *date blank)*. START _____ END _____		
b. if you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐
c. was this your first time in this type of Medicare plan?	☐	☐
d. did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐	☐
4. a. Do you have another Medicare Supplement policy in force?	☐	☐
b. If so, with what company and what type plan do you have? _____		
_____		
c. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐	☐
If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.		
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?	☐	☐
a. If so, with what company and what kind of policy? _____		
_____		
b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave the* END *date blank.)* START _____ END _____		

Section VI. Medicare

	YES	NO
1. Do you now have Medicare Parts A and B?	☐	☐
If YES, give effective date of Part B _____		
2. If Medicare Parts A and B are to be effective at a future date, provide the date both Medicare Parts A and B will be effective _____		

NOTE: Medicare effective date is always the 1st day of the month. You must have both Medicare Parts A and B on the effective date of the policy. If not, coverage cannot be issued.

Section VII. Medical Questions

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) V & VI), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage. If you answered NO to all questions in this Section, please continue to Part B.

		YES	NO
1.	Are you currently confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	☐	☐
2.	Do you currently receive home health care services or, in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	☐	☐
3.	Do you currently have a terminal illness or are you currently in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	☐	☐
4.	Do you currently receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; or have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐
5.	Do you have now or in the last two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for the following conditions:		
	a. internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma?	☐	☐
	b. angina, atherosclerosis, arteriosclerosis, peripheral vascular disease, heart attack, irregular heartbeat, atrial fibrillation, cardiomyopathy, congestive heart failure, angioplasty, stent placement, carotid artery disease, coronary artery disease (CAD), heart valve surgery, coronary bypass, cardiac pacemaker, implantable or subcutaneous defibrillator? (You should answer NO if your only treatment is with maintenance medication.)	☐	☐
	c. Parkinson's disease, myasthenia gravis, cerebral palsy, muscular dystrophy, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease)?	☐	☐
	d. Paget's disease, rheumatoid arthritis, disabling arthritis, systemic lupus, osteoporosis with fractures, or paralysis?	☐	☐
	e. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
	f. diabetes with hypertension requiring three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	☐	☐
	g. diabetes with: neuropathy, retinopathy, vascular disease, or tobacco use?	☐	☐
	h. chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or any other chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
	i. major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
	j. dementia, senility, Alzheimer's disease, or organic brain disorder?	☐	☐
	k. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder?	☐	☐
	l. hepatitis (other than hepatitis A), alcohol or drug abuse, cirrhosis of the liver, or other liver disease?	☐	☐
	m. stroke or transient ischemic attack (TIA)?	☐	☐
6.	Do you have now or at any time have you been treated for or advised by a medical professional to have treatment for amputation caused by disease or organ transplant other than corneas?	☐	☐
7.	Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	☐	☐
8.	Have you been positively diagnosed with or at any time have you received treatment or been advised to have treatment for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immuno-deficiency Virus (HIV) infection?	☐	☐

Section VII. Medical Questions *(cont'd.)*

PART B. HEIGHT/WEIGHT AND MEDICATIONS – The answers to questions in Part B are subject to the Company's Underwriting review. Please provide complete details as requested.

9. Height *(ft.-in.)* _____ Weight *(lbs.)* _____

10. Please list any prescription medications taken or prescribed in the past two (2) years.

Medication	Dates taken	Condition taken for

AGENT NOTES – Please confirm the Applicant's Medicaid coverage will end prior to the effective date of the Medicare Supplement coverage:

_____

_____

_____

_____

Section VIII. Important Statements for Applicant to Read

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

I hereby apply to Cigna Health and Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for, the required *Guide to Health Insurance for People with Medicare*, and the MIB Notice.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Telephone number (_____)_____ **Best time to call** _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

Applicant's printed name _____

Signature of Applicant _____ **Date** _____

Section IX. Agent(s) Certification

Agent(s) shall list any health insurance policies they have sold to the Applicant.

1. List policies sold which are still in force *(if this does not apply, state "NONE")*.

   _____

   _____

2. List policies sold in the past five (5) years which are no longer in force *(if this does not apply, state "NONE")*.

   _____

   _____

	YES	NO
3. Have you reviewed the application for correctness and omissions?	☐	☐

4. I certify that I have provided the Applicant with the following documents:
   a. Application packet *(phone sales only)*
   b. *Guide to Health Insurance for People with Medicare*
   c. Outline of Medicare Supplement Coverage
   d. MIB Notice
   e. other _____

   I further certify that I have delivered the documents to the Applicant *(check all that apply; must select at least one)*:

   ☐ In person _____ date
   ☐ Mail _____ date
   ☐ Email _____ date
   ☐ Fax _____ date
   ☐ other *(explain)* _____ _____ date

	YES	NO
5. Was the application completed by you in the Applicant's physical presence?	☐	☐
6. Was the application completed by you over the phone?	☐	☐
7. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?	☐	☐

If YES, give name of Company, reason, and termination date

_____

_____

_____

I certify that I have interviewed the Applicant, asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant.

Printed name of licensed Agent	Signature of licensed Agent	Writing number	Percentage
Printed name of 2nd licensed Agent	Signature of 2nd licensed Agent	Writing number	Percentage