# APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
## Loyal American Life Insurance Company

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

Application is for: ☐ New Business ☐ Underwritten ☐ Disabled (underage)
☐ Open Enrollment ☐ Guaranteed Issue ☐ Reinstatement ☐ Benefit Change

Requested Medicare Supplement effective date* _____ PV 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 Loyal American 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 of the individual(s) living at your current address.*

**Spouse/Household Member Name** **Spouse/Household Member SSN**

| First Name | MI | Last Name | xxx-xx-xxxx |
|---|---|---|---|
| | | | |
| | | | |

**Section II.** Coverage Applied for

**Check Plan selected:** ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan 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 ***Loyal American Life Insurance Company***)

*initial premium payment must include the one-time enrollment fee

| | |
|---|---|
| Modal Premium (if Household Discount, then multiply modal premium by 0.88) | $_____ |
| Total Modal Premium (with discount(s) if applicable) | $_____ |
| One-time Enrollment Fee | $ 0 |
| 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. Applicant 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.

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

If the answer to any question in this section is YES, the Applicant is not eligible for coverage.

| | | YES | NO |
|---|---|---|---|
| 1. | Are you currently confined or scheduled for admission to a hospital, nursing facility, or assisted living facility or are you receiving home health care services? | ☐ | ☐ |
| 2. | Do you require or receive any assistance with any of your activities of daily living such as bathing, transferring, toileting, eating, dressing, or continence? | ☐ | ☐ |
| 3. | Are you currently bedridden or do you use the assistance of a wheelchair, walker, or motorized mobility aid? | ☐ | ☐ |
| 4. | Within the last two (2) years, have you: | | |
| | a. been hospitalized more than two (2) times or received home health care services more than three (3) times? | ☐ | ☐ |
| | b. been confined to a nursing facility for more than 30 days? | ☐ | ☐ |
| | c. been diagnosed with, treated for, or taken medication for angina, heart attack, heart or heart valve surgery, implantation of cardiac pacemaker or defibrillator, cardiomyopathy, congestive heart failure, cardiac or vascular angioplasty, stent placement, peripheral vascular disease, bypass, endarterectomy, carotid artery disease, coronary artery disease, or heart disease? | ☐ | ☐ |
| | d. had a stroke or transient ischemic attack (TIA)? | ☐ | ☐ |
| 5. | Do you have now or in the last two (2) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions: | | |
| | a. hepatitis, cirrhosis of the liver, or other liver disease? | ☐ | ☐ |
| | b. major depression, bipolar disorder, schizophrenia, or a paranoid disorder? | ☐ | ☐ |
| | c. insulin-dependent diabetes; diabetes with neuropathy, retinopathy, or vascular disease; chronic kidney disease; Addison's disease; renal insufficiency, renal failure, or any kidney disease requiring dialysis; or any condition requiring an organ transplant? | ☐ | ☐ |
| | d. internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? | ☐ | ☐ |
| | e. alcohol or drug abuse? | ☐ | ☐ |
| | f. paralysis, hemophilia, osteoporosis with fractures, or unrepaired aneurysm? | ☐ | ☐ |
| | g. Paget's disease, rheumatoid or disabling arthritis, lupus, or other connective tissue disorder? | ☐ | ☐ |
| 6. | Do you have now or at any time have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for the following conditions: | | |
| | a. Parkinson's disease, myasthenia gravis, multiple or amyotrophic lateral sclerosis (Lou Gehrig's disease), muscular dystrophy, cerebral palsy, dementia, senility, Alzheimer's disease, or organic brain disorder? | ☐ | ☐ |
| | b. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) Infection? | ☐ | ☐ |
| | c. emphysema, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD) excluding asthma? or any lung or respiratory disorder requiring the use of oxygen? | ☐ | ☐ |
| | d. amputation caused by disease or organ transplant other than corneas? | ☐ | ☐ |
| 7. | Do you have now or in the last three (3) years have you received medical advice, treatment, or been advised to have treatment, surgery, or taken medication for anemia requiring repeated blood transfusions, any other blood disorder, or disorder of the pancreas? | ☐ | ☐ |
| 8. | Has surgery been advised but not performed or is any surgery anticipated, including cataract surgery? | ☐ | ☐ |
| 9. | Have medical tests, treatment, or therapy been advised but not performed? | ☐ | ☐ |

10. If you are not taking any medications, please check here: ☐ I am not taking any medications.
Please list any prescription medications taken or prescribed in the past two (2) years.

| Medication | Dates taken | Condition taken for |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

*NOTE: Please attach a separate sheet if needed.*

AGENT NOTES - Please provide any other information that you believe may assist in our underwriting determination:

_____

_____

_____

_____

## **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 Loyal American 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 submitted any applications or have knowledge of any applications submitted for this Applicant that have been declined? ..... If YES, provide details below. | ☐ | ☐ |
| 4. Have you reviewed the application for correctness and omissions? ..... | ☐ | ☐ |

5. 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 |
|---|---|---|
| 6. Was the application completed by you in the Applicant's physical presence? ..... | ☐ | ☐ |
| 7. Was the application completed by you over the phone? ..... | ☐ | ☐ |
| 8. 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 |

# MEDICARE SUPPLEMENT SUPPLEMENTARY APPLICATION

Loyal American Life Insurance Company | PO Box 5725, Scranton, PA 18505-5725

# MEDICARE SUPPLEMENT SUPPLEMENTARY APPLICATION

## Definitions of Eligible Person for Guaranteed Issue

An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:
   (A) The certification of the organization or plan has been terminated; or
   (B) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
   (C) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
   (D) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
      (i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
      (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
   (E) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) - (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:
   (A) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost);
   (B) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
   (C) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
   (D) An organization under a Medicare Select policy; and

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:
   (A) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy;
   (B) The issuer of the policy substantially violated a material provision of the policy; or
   (C) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act);

(6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

If any of the definitions apply to you, please complete an Application for Medicare Supplement Insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

I acknowledge receipt of this Supplementary Application.

_____ _____

**Signature of Applicant** **Date**