**Instructions to Agent**: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna National Health Insurance Company (CNHIC) with the application.

***A copy of this form must also be left with the Applicant.***

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

CIGNA NATIONAL HEALTH INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Cigna National Health Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

**Applicant A**

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) ____________________

____________________________________

**Applicant B**

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) ____________________

____________________________________

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.**

____________________________________ ____________
**Agent/Broker printed name and signature** **Date**

____________________________________ ____________
**Applicant A signature** **Date**

____________________________________ ____________
**Applicant B signature** **Date**

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- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) ____________________

____________________________________

**Applicant B**

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) ____________________

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______________________________________________ ____________________
**Agent/Broker printed name and signature** **Date**

______________________________________________ ____________________
**Applicant A signature** **Date**

______________________________________________ ____________________
**Applicant B signature** **Date**