APPLICATION for MEDICARE SUPPLEMENT INSURANCE

Cigna National Health Insurance Company, an Ohio domiciled company
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272 • www.Cigna.com
Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186

Application is for: ☐ New business ☐ Reinstatement Phone verification case #(s) ____________________

- If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.
- If only one Applicant, complete Applicant A questions.

A. Personal information

Applicant A

Name *(First MI Last)*	**Age**	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)*	**Phone** ( )
Mailing address *(if different from resident address)*	**Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically.*

Applicant B

Name *(First MI Last)*	**Age**	**Date of birth** *(MM/DD/YYYY)*	**Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* – OR check box ☐ if same as Applicant A	**Phone** ( )
Mailing address *(if different from resident address)*	**Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically.*

Premium discount (see Outline of Coverage for details)	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
1. a. Do you live with someone 18 years or older (6% premium discount)?	☐	☐	☐	☐
b. If YES, do they have a Medicare Supplement policy with Cigna National Health Insurance Company or an affiliate of Cigna National Health Insurance Company (an additional 9% premium discount)?	☐	☐	☐	☐

2. If you answered YES to 1b, please provide member information if other than Applicant A or Applicant B.

Name *(First MI Last)*	**Social Security no.** *(XXX-XX-XXXX)*

B. Please provide your Medicare information *(as shown on your Medicare card)*

Applicant A	Applicant B
Medicare number ____________________	Medicare number ____________________
Hospital (Part A) coverage starts *(MM/DD/YYYY)* __________	Hospital (Part A) coverage starts *(MM/DD/YYYY)* __________
Medical (Part B) coverage starts *(MM/DD/YYYY)* __________	Medical (Part B) coverage starts *(MM/DD/YYYY)* __________

You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

C. Select a plan and effective date

APPLICANT A Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

APPLICANT B Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

Requested Medicare Supplement effective date (*MM/DD/YYYY*) **A** ____________ **B** ____________

(if no effective date is requested, we will assign the 1st day of the month following the date of this application)

*Plan F is only available if you are first Medicare-eligible before 2020.

D. Are you eligible for Open Enrollment or Guaranteed Issue?

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:

	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B 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? (*MM/DD/YYYY*) **A** ____________ **B** ____________				
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)*.

A START ____________ END ____________

B START ____________ END ____________

	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
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?

A ____

B ____

	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
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?

A ____

B ____

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.)*

A START ____________ END ____________

B START ____________ END ____________

E. Complete medical questions

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) B & D), 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.

Question	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
1. Are you 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 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 have a terminal illness; are you 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 now receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; or within the last two (2) years, have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐	☐	☐
5. Within the past six (6) months, have you been treated for or advised by a medical professional to have treatment for diabetes with hypertension that required three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	☐	☐	☐	☐
6. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • heart attack, congestive heart failure, coronary bypass, or stroke? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases).)	☐	☐	☐	☐
7. Do you have now or in the last five (5) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)? • Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis? • chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, or any condition requiring an organ transplant? • bipolar disorder, schizophrenia, a paranoid disorder, severe depression, or treatment for depression with medication for two (2) or more years? • organic brain disorder? • unrepaired aneurysm, hemophilia, or any other blood disorder? • any heart disease requiring a permanent, implantable cardiac defibrillator?	☐	☐	☐	☐
8. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • any cancer, excluding skin cancer (except malignant melanoma)? • anemia requiring repeated blood transfusions? • alcohol or drug abuse (including counseling)? • pancreatitis?	☐	☐	☐	☐
9. Do you have now or within the last five (5) years, have you been treated for or advised by a medical professional to have treatment for an amputation caused by disease or for an organ transplant (other than corneas)?	☐	☐	☐	☐
10. Do you have now or within the last two (2) years, 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.)	☐	☐	☐	☐
11. Do you have now or within the last five (5) years, have you been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	☐	☐	☐	☐

If you answered NO to all questions in this Section, please continue to Part B. >>>

E. Complete medical questions *(cont'd.)*

PART B. MEDICAL QUESTIONS AND MEDICATIONS – The answers to questions in Part B are subject to the Company's underwriting review. Please provide complete details as requested.

12. **APPLICANT A** Height *(ft.-in.)* ____________ Weight *(lbs.)* ________

    APPLICANT B Height *(ft.-in.)* ____________ Weight *(lbs.)* ________

Question	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
13. a. Have you used tobacco within the last 12 months?	☐	☐	☐	☐
b. If YES, do you currently have a heart condition, vascular condition, or diabetes?	☐	☐	☐	☐
14. In the last two (2) years, have you been treated for or advised by a medical professional to have treatment for any of the following:	☐	☐	☐	☐

- angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, transient ischemic attack (TIA)? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases).)

15. Do you have now or within the last five (5) years, have you been treated for or advised by a medical professional to have treatment for any of the following:

Condition	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
• chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or other chronic lung or respiratory disorder not listed that requires the permanent use of oxygen?	☐	☐	☐	☐
• diabetes with neuropathy, diabetes with retinopathy, or diabetes with vascular disease?	☐	☐	☐	☐
• cerebral palsy, myasthenia gravis, systemic lupus, or Parkinson's disease?	☐	☐	☐	☐
• hepatitis other than hepatitis A, cirrhosis of the liver, or other liver disease?	☐	☐	☐	☐
• dementia, senility, or Alzheimer's disease?	☐	☐	☐	☐
• PSA levels greater than 6.0?	☐	☐	☐	☐

16. Please list any prescription medications taken or prescribed in the past two (2) years *(attach a separate sheet if needed)*.

Medication name	Dates taken	Reason for medication
APPLICANT A		
APPLICANT B		

F. 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).

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

I hereby apply to Cigna National Health 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 and the required *Guide to Health Insurance for People with Medicare*.

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.

Applicant A Telephone number (______) ____________________ Best time to call ____________________

Applicant B 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 A Signature ______________________________ Date ____________________

Applicant B Signature ______________________________ Date ____________________

G. Determine your rate class

A	B	Rate class	
☐	☐	**Preferred**	If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, questions 13a, 14, and 15.
☐	☐	**Standard**	If you answered YES to section E, question 13a (tobacco use), and NO to questions 13b, 14, and 15.
☐	☐	**Standard II**	If you answered NO to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.
☐	☐	**Standard III**	If you answered YES to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.

Your final rate class is subject to underwriting review. Medications and height and weight impact your rate class. Please refer to the declinable drug list and height and weight chart for guidance.

H. Choose your method of payment

Applicant A
Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*
☐ Direct bill *(enclose check payable to* **Cigna National Health Insurance Company**; *do not send cash)*
☐ List bill Group name ______________________________ Group number ______________

Mode: ☐ Monthly *(bank draft or list bill only)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $__________________

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.
If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.85.

Applicant B
Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*
☐ Direct bill *(enclose check payable to* **Cigna National Health Insurance Company**; *do not send cash)*
☐ List bill Group name ______________________________ Group number ______________

Mode: ☐ Monthly *(bank draft or list bill only)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $__________________

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.
If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.85.

I. Agent use only

Please answer all questions:

1. I certify that I have provided the Applicant(s) 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. Other ______________________________

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

   Date ______________ ☐ In person ☐ Mail ☐ Email ☐ Fax ☐ Other *(explain)* ______________

2. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?

   Applicant A: ☐ YES ☐ NO **Applicant B:** ☐ YES ☐ NO

   If YES, give name of company, reason, and termination date:

   A ____

   B ____

NOTES: Please provide additional information that may assist in processing this application (*attach a separate sheet if needed)*.

____

I certify that I have interviewed the Applicant(s), 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(s).

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

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