GUIDELINES

Agent Underwriting Guidelines For Medicare Supplement

July 2020

Contacts

New Business	Overnight Delivery Only
CSO	CSO
Medicare Supplement Administration	17757 US HWY 19 N
P.O. Box 10844	Suite 660
Clearwater, FL 33757-8844	Clearwater FL 33764

Phone Numbers / Fax Numbers / Website

Claims, Underwriting, Customer Service and Commissions	1-833-522-4874
Underwriting Fax	1-855-255-8653
New Business Fax – New Application Submission Only	1-855-304-2855
Marketing Support	1-866-644-3988
Agent Licensing	1-800-321-0102 678-483-8513 (fax)
Supplies	1-800-321-0102 1-866-888-1330 (fax)
Agent Portal Website	www.csoeapp.com

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INTRODUCTION

This guide provides information about the evaluation process used in underwriting and issuing CSO Medicare Supplement insurance policies. It is CSO's objective to be consistent with each state's Unfair Trade Practices Act in the offering of coverage and to issue insurance policies quickly and efficiently while ensuring proper evaluation of each risk. To assist in accomplishing this objective, writing agents are notified via the agent portal advising of problem(s) with an application. All policies and procedures are as of the revision date listed on the front cover and are subject to change.

POLICY ISSUE GUIDELINES

Policy issue is state specific. The applicant's state of residence controls the application, forms, premium and policy issue. If an applicant has more than one residence, the state where taxes are filed is considered the state of residence.

A. Open Enrollment

To be eligible for open enrollment, an applicant must be 64 ½ years of age or older (in most states) and apply for a Medicare supplement policy within six months of their first-time enrollment in Medicare Part B.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month open enrollment period upon reaching age 65.

B. Selective Issue

Applicants 65 years of age or older and who are six or more months beyond enrollment in Medicare Part B will be medically underwritten (unless applying in a guarantee issue period).

The Health Questions Section of the application must be answered; answers to these health questions will determine eligibility for coverage.

- Each state's application contains an initial set of questions that If the applicant answers "yes" to any of the questions, the applicant is ineligible for coverage.
- Each state's application also contains a second set of questions that If the applicant answers "yes" to any of those questions, individual consideration will be given, and they may be eligible for coverage. An explanation must be provided if the applicant answered "yes" to any of these individual consideration questions.

Prescription drug information will be evaluated against the applicant's responses to determine consistency. Both the drugs listed on the application and any prescription drug information returned from the prescription drug screen will be used to verify eligibility.

C. Eligibility

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Coverage will be declined for those applicants who are outside the established height and weight guidelines.

To determine if the applicant is eligible for coverage, locate the applicant's height, then weight (in pounds) in the chart below. If the applicant's weight is in either of the decline columns, they are currently not eligible for coverage.

Height	APPLICANT HEIGHT AND WEIGHT (LBS.)					
	FEMALE WEIGHT			MALE WEIGHT		
	Decline	Issue	Decline	Decline	Issue	Decline
4'2"	< 54	54 - 138	> 138	< 59	59 - 145	> 145
4'3"	< 56	56 - 143	> 143	< 62	62 - 151	> 151
4'4"	< 58	58 - 149	> 149	< 64	64 - 157	> 157
4'5"	< 60	60 - 155	> 155	< 66	66 - 163	> 163
4'6"	< 63	63 - 162	> 162	< 69	69 - 170	> 170
4'7"	< 65	65 - 167	> 167	< 71	71 - 176	> 176
4'8"	< 67	67 - 173	> 173	< 74	74 - 182	> 182
4'9"	< 70	70 - 180	> 180	< 77	77 - 189	> 189
4'10"	< 72	72 - 186	> 186	< 79	79 - 196	> 196
4'11"	< 75	75 - 192	> 192	< 82	82 - 202	> 202
5'0"	< 77	77 - 199	> 199	< 85	85 - 209	> 209
5'1"	< 80	80 - 205	> 205	< 88	88 - 216	> 216
5'2"	< 83	83 - 213	> 213	< 91	91 - 224	> 224
5'3"	< 85	85 - 219	> 219	< 93	93 - 231	> 231
5'4"	< 88	88 - 226	> 226	< 97	97 - 238	> 238
5'5"	< 91	91 - 234	> 234	< 100	100 - 246	> 246
5'6"	< 93	93 - 241	> 241	< 102	102 - 254	> 254
5'7"	< 96	96 - 248	> 248	< 105	105 - 261	> 261
5'8"	< 99	99 - 256	> 256	< 109	109 - 269	> 269
5'9"	< 102	102 - 263	> 263	< 112	112 - 277	> 277
5'10"	< 105	105 - 271	> 271	< 115	115 - 285	> 285
5'11"	< 108	108 - 278	> 278	< 119	119 - 293	> 293
6'0"	< 111	111 - 287	> 287	< 122	122 - 302	> 302
6'1"	< 114	114 - 295	> 295	< 125	125 - 310	> 310
6'2"	< 117	117 - 303	> 303	< 129	129 - 319	> 319
6'3"	< 121	121 - 312	> 312	< 133	133 - 328	> 328
6'4"	< 124	124 - 319	> 319	< 136	136 - 336	> 336
6'5"	< 127	127 - 328	> 328	< 140	140 - 345	> 345
6'6"	< 130	130 - 336	> 336	< 143	143 - 354	> 354
6'7"	< 134	134 - 345	> 345	< 147	147 - 363	> 363
6'8"	< 137	137 - 354	> 354	< 151	151 - 373	> 373
6'9"	< 140	140 - 363	> 363	< 154	154 - 382	> 382
6'10"	< 144	144 - 372	> 372	< 158	158 - 392	> 392
6'11"+	< 147	147 - 381	> 381	< 162	162 - 401	> 401

D. Application Sign Dates

- Open Enrollment – Up to six months prior to the month the applicant turns age 65.
- Underwritten Cases – Up to 60 days prior to the requested coverage effective date.

E. Coverage Effective Dates

Coverage will be made effective as indicated below:

- For Open Enrollment, the latest effective date allowed is the last day of the applicant's Open Enrollment window.
- The effective date of the insurance can be between the 1st and the 28th day of the month.
- Applications written for an effective date of the 29th, 30th, or 31st of the month will be made effective on the 1st of the next month.
- Applications may not be backdated prior to the application signed date for any reason to save age.

Exception: For Open Enrollment only, applications signed on the 29th, 30th, or 31st of the month may be dated the 28th of the same month upon request.

F. Replacements

A "replacement" takes place when an applicant wishes to terminate their existing Medicare Supplement policy and replace with another available Medicare Supplement plan.

- Internal replacements with an upgrade in benefits are processed the same as external, requiring a fully completed application with medical underwriting. The state specific policy fee is required.
- Internal replacements with a decrease in benefits, require a signed request from the insured.

Please note: If an internal replacement originally qualified for guarantee issue, the insured will only be allowed to downgrade to a plan with decreased benefits available under the pertinent guarantee issue rule. Please see Guarantee Issue Rules.

An insured wanting to apply for a non-tobacco plan must complete a new application and qualify for coverage.

An insured wanting to replace a plan from a different state must complete a new application. Medical underwriting is required unless in an Open Enrollment or Guaranteed Issue period. The state specific policy fee is required.

The policy to be replaced must be in force on the date of replacement. All replacements involving a Medicare Supplement, Medicare Select, Medicare Advantage or Medicare Cost/HMO plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application.

G. Reinstatements

When a Medicare Supplement policy has lapsed, and it is within 90 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements.

When a Medicare Supplement policy has lapsed, and it is more than 90 days beyond the last paid to date, coverage cannot be reinstated. The applicant may, however, apply for new coverage. All underwriting requirements must be met before a new policy can be issued.

H. Telephone Interviews

Random telephone interviews with applicants will be conducted on underwritten cases. Applicants are to be notified telephone calls will be made to verify the information on their application.

I. Pharmaceutical Information

To obtain pharmaceutical information on underwritten Medicare Supplement applications, the Authorization and Certification page of the application must be completed and signed by the applicant. Prescription information noted on the application will be compared to the additional pharmaceutical information received. Pharmaceutical information obtained from the prescription drug screen will not be used solely as a reason to decline an application. Information will be verified with either the applicant or a physician before using as a reason to decline an application.

J. Policy Delivery Receipt

Delivery receipts are required on all policies issued in:

- Nebraska
- South Dakota

Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the applicant. The second copy must be returned to the Company in the return envelope, which is also included in the policy package.

GUARANTEE ISSUE RULES

A. Original Medicare Supplement Guarantee Issue Rules

The rules listed below can also be found in the Guide to Health Insurance. These are the Federal requirements.

Leaving an employer group voluntarily does not always create applicant eligibility for guarantee issue. In this situation, state laws may vary.

Guarantee Issue Situation	Applicant has the right to buy. . .
Applicant is in original Medicare and has employer group health coverage (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending. **Note: In this situation, state laws may vary.**	Medigap Plan A, B, C*, D**, F*, High deductible F*, G**, High deductible G**, K or L that is sold in client's state by any insurance company. If applicant has COBRA coverage, applicant can either buy a Medicare Supplement policy right away or wait until the COBRA coverage ends.
Applicant is in original Medicare and has a Medicare SELECT policy. Applicant moves out of the Medicare SELECT plan's service area. Applicant can keep Medicare policy or switch to another Medicare policy.	Medigap Plan A, B, C*, D**,F*, High deductible F*, G**, High deductible G**, K or L that is sold by any insurance company in client's state or the state he/she is moving to.
Applicant's Medicare Supplement insurance company goes bankrupt and the applicant loses coverage, or Medicare Supplement policy otherwise ends through no fault of applicant.	Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in client's state by any insurance company.

For state specific Guaranteed Issue scenarios, please see the state GI Checklist. The checklist can be found on the agent portal at the back of the application or you can request a copy from supplies.

*Plans C and F are not available to newly eligible Medicare beneficiaries.

**Plans D and G are only available to newly eligible Medicare beneficiaries in the above guarantee issue situations.

B. Medicare Advantage (MA) Issue Rules

MA Election and Disenrollment Periods

General Election Periods for Medicare Advantage (MA)	Timeframe	Allows for…
Annual Election Period (AEP)	Oct. 15th – Dec. 7th of every year	• Enrollment selection for a MA plan • Disenroll from a current MA plan • Enrollment selection for Medicare Part D
Medicare Advantage Disenrollment Period (MADP)	Jan. 1st – Feb 14th of every year	• MA enrollees to disenroll from any MA plan and return to Original Medicare. The MADP does not provide an opportunity to: • Switch from original Medicare to a MA Plan. • Switch from one MA Plan to another. • Switch from one Medicare Prescription Drug plan to another. • Join, switch or drop a Medicare medical Savings Account plan.

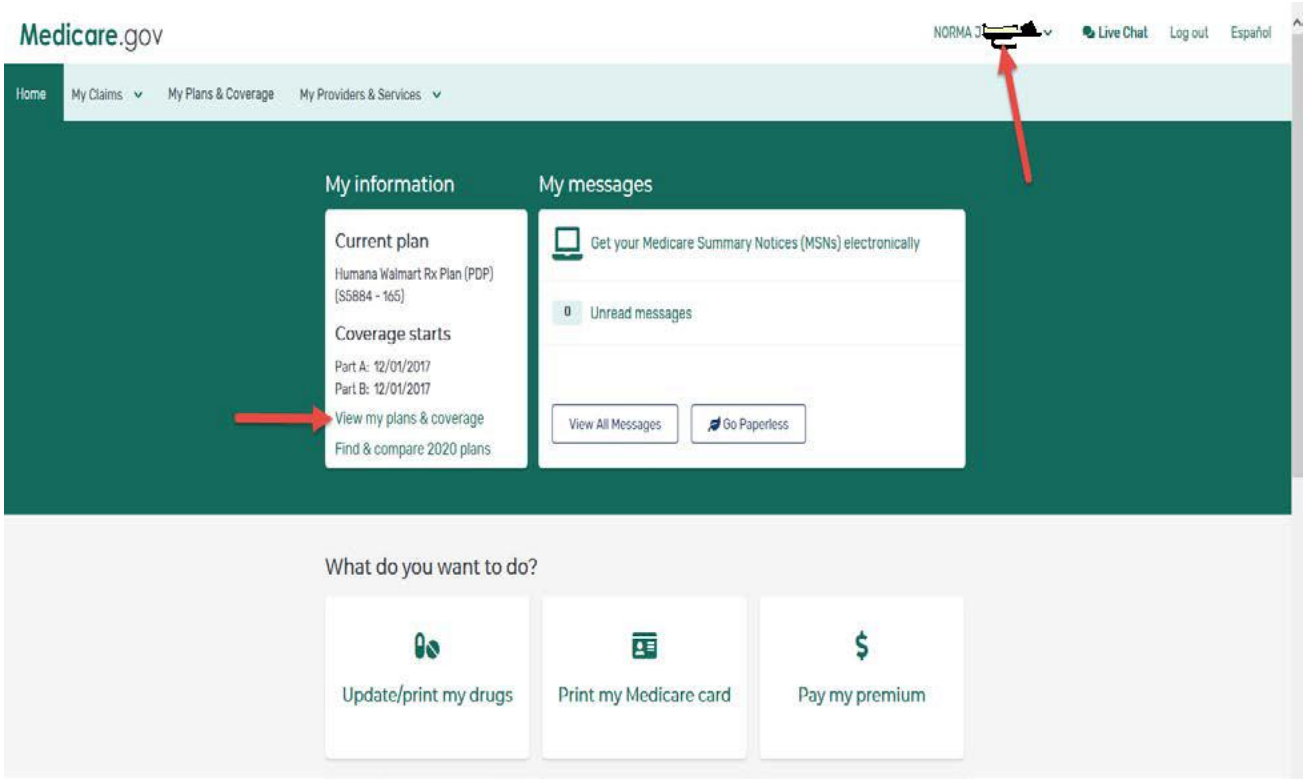
There are many types of election periods other than the ones listed above. Refer the applicant to the local State Health Insurance Assistance Program (SHIP) office for direction on disenrollment from MA.

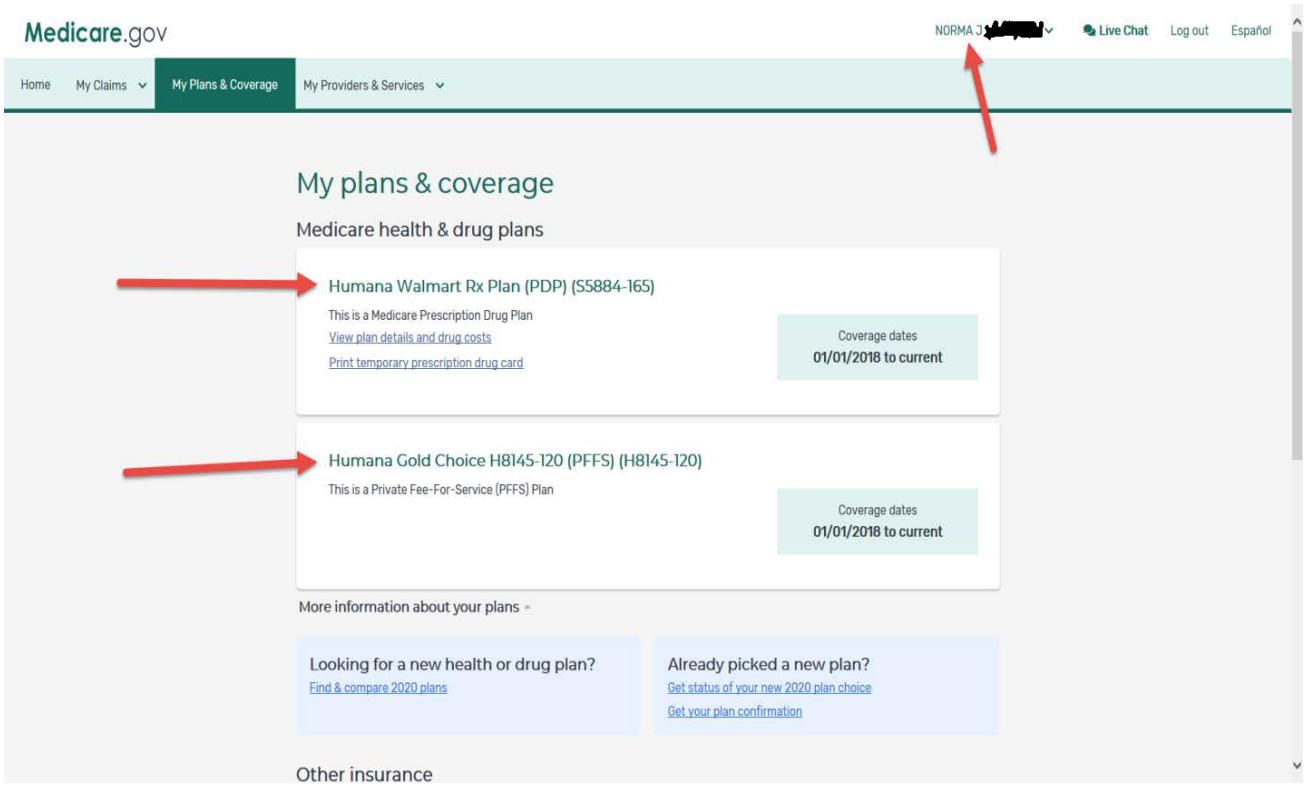
MA Proof of Disenrollment

Underwriting cannot issue Medicare Supplement coverage without proof of Medicare Advantage disenrollment. If a member disenrolls from a Medicare Advantage plan, the plan must notify the member of his/her rights to buy other coverage.

Disenrolling from a Medicare Advantage Plan

- Complete the Medicare Advantage question in the replacement section on the Medicare Supplement application.
- For Guaranteed Issue applications, proof of a qualifying event must be submitted.
- For Underwritten or Open Enrollment applications, once the application has been approved, the agent will be notified via an agent portal message and advised to begin the disenrollment process from the Medicare Advantage plan.
- A policy will not be mailed until we are able to confirm disenrollment from the Medicare Advantage Plan and that our effective date does not overlap any Medicare Advantage coverage. For proof of a Medicare Advantage Plan disenrollment please submit the disenrollment letter or screenshots of the disenrollment status on Medicare.gov.


Medicare.gov
NORMA J
Live Chat
Log out
Español
Home
My Claims
My Plans & Coverage
My Providers & Services
My information
My messages
Current plan
Humana Walmart Rx Plan (PDP)
(S5884 - 165)
Coverage starts
Part A: 12/01/2017
Part B: 12/01/2017
View my plans & coverage
Find & compare 2020 plans
Get your Medicare Summary Notices (MSNs) electronically
0
Unread messages
View All Messages
Go Paperless
What do you want to do?
Update/print my drugs
Print my Medicare card
Pay my premium


Medicare.gov
NORMA J
Live Chat
Log out
Español
Home
My Claims
My Plans & Coverage
My Providers & Services
My plans & coverage
Medicare health & drug plans
Humana Walmart Rx Plan (PDP) (S5884-165)
This is a Medicare Prescription Drug Plan
View plan details and drug costs
Print temporary prescription drug card
Coverage dates
01/01/2018 to current
Humana Gold Choice H8145-120 (PFFS) (H8145-120)
This is a Private Fee-For-Service (PFFS) Plan
Coverage dates
01/01/2018 to current
More information about your plans
Looking for a new health or drug plan?
Find & compare 2020 plans
Already picked a new plan?
Get status of your new 2020 plan choice
Get your plan confirmation
Other insurance

C. Medicare Advantage Guarantee Issue Rights

The rights listed below can also be found in the Guide to Health Insurance. These are the Federal requirements.

Guarantee Issue Situation	Applicant has the right to…
Applicant's MA plan is leaving the Medicare program, stops providing care in area, or applicant moves out of the plan's service area.	Buy a Medigap Plan A, B, C*, D** F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in the client's state by any insurance carrier. Client must switch to Original Medicare Plan.
Applicant joined an MA plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to original Medicare.	Buy any Medicare Supplement plan that is sold in the state by any insurance company.
Applicant canceled a Medicare Supplement policy and joined a MA Plan for the first time. Applicant has been in the MA plan for less than a year and wants to return to a Medicare Supplement policy.	Obtain applicant's Medicare Supplement policy back if still offered by the carrier. If former Medicare Supplement policy is not available, the applicant can buy Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in his/her state by any insurance company.
Applicant leaves an MA plan because the company has not followed the rules or has misled the applicant.	Buy a Medigap Plan A, B, C*, D** F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in the client's state by any insurance carrier

*Plans C and F are not available to newly eligible Medicare beneficiaries.

**Plans D and G are only available to newly eligible Medicare beneficiaries.

PREMIUM

A. **Calculating Premium**

- Determine ZIP code where the applicant resides and find the correct rate card for that ZIP code
- Determine Plan
- Determine if non-tobacco or tobacco
- Find age/gender - verify that the age and date of birth are the exact age as of the effective date
- Use the following modal factors to calculate the correct modal premium based off the annual premium rate
    - ✓ Annual
    - ✓ Semiannual (Modal Factor = .50)
    - ✓ Quarterly (Modal Factor = .250)
    - ✓ Monthly* (Modal Factor = Divide by 12)

We do not offer a Monthly direct bill option.

B. **Household Premium Discount**

The eligibility requirements for the Household Premium Discount are:

State		Eligibility
Alabama Arizona Iowa Florida* Georgia Illinois Kansas Kentucky Louisiana Michigan Nebraska Nevada	New Jersey North Carolina North Dakota Oklahoma Ohio South Carolina South Dakota Tennessee Texas Utah Virginia West Virginia Wyoming	▪ Currently living with spouse, including validly recognized civil union and domestic partners, OR ▪ Currently have a household resident (at least one, no more than three) with whom has continuously resided for the last 12 months.
In addition:	Florida Illinois New Jersey Ohio Oklahoma	▪ Requires spouse or additional resident(s) to have a CSO Medicare Supplement policy.
In addition:	North Dakota	▪ Household resident must be of family relation AND requires spouse or additional resident(s) to have a CSO Medicare Supplement policy.
Indiana		▪ Currently married or have a legal spouse, including validly recognized civil union and domestic partners, OR ▪ Currently have a household resident (at least one, no more than three) with whom has continuously resided for the last 12 months.

	▪ Requires spouse or additional resident(s) to have a CSO Medicare Supplement policy.
Montana	For the past year, resided with: ▪ Spouse, including validly recognized civil union and domestic partners, OR ▪ A household resident (at least one, no more than three)
Pennsylvania	▪ Currently living with your legal spouse OR ▪ currently have a household resident (at least one, no more than three) with whom has continuously resided for the last 12 months. The household resident must have a CSO Medicare Supplement policy.
Idaho	Not Available

*The Household Premium Discount is 7% in all states, except Florida which is 3%.

When an applicant meets the state's Household Premium Discount eligibility requirements, any existing CSO Medicare Supplement policyholder(s) will be given the discount on their next policy billing cycle.

The Household Premium Discount will remain in effect for the life of the policy, except for Florida, Indiana, Illinois, New Jersey, North Dakota, Ohio, Oklahoma, and Pennsylvania (applies to household resident only), which require the discount be removed when the eligibility requirements are no longer met.

C. **Sample Premium Calculations:**

Non-Tobacco Premium Rate Sheet

Attained Age	**Plan C**	
	Male	Female
65	$1,549	$1,347
66	$1,549	$1,347
67	$1,622	$1,410
68	$1,696	$1,474

Modal Factors	**Semi-Annual**	**Quarterly**	**Monthly**
	0.50	0.25	1/12

Discount to be calculated as follows:
Annual premium x 0.93 (7% Household Discount) = Discounted Annual premium multiplied or divided by the modal factor (rounded to the nearest cent).

Applicant #1
Male, Non-tobacco user, age 68, applying for a plan C with Household Discount
Annual premium $1,696 x 0.93 = **$1,577.28**
Semi-annual premium $1,696 x 0.93 = $1,577.28 multiplied by 0.50 = **$788.64**
Quarterly premium $1,696 x 0.93 = $1,577.28 multiplied by 0.25 = **$394.32**
Monthly premium $1,696 x 0.93 = $1,577.28 divide by 12 = **$131.44**

Note: After total Premium is calculated add the state specific one-time policy fee for each applicant.

D. **Completing the Premium on the Application**

The payment mode should be selected on the application, with the first modal premium (including any policy fee) indicated either in the Premium Collected or Initial Bank Draft section.

If an application is submitted without premium, the first modal premium and policy fee (if applicable) will be drafted on Issue Date or Effective Date as indicated on the application.

If neither is selected on the application for the Initial Bank Draft, the first modal premium and policy fee will be drafted **on or after the effective date of the policy.**

E. **Premium Payments**

For premium payments made by check, the check is made out to Central States Health & Life Co. of Omaha.

The Company does not accept post-dated checks, cash, agent or agency check, money orders, traveler's checks, initial or renewal premiums from a Third-Party Payor that have no family or business relationship to the applicant, or foundation, except where prohibited by law.

F. **Electronic Payment Authorization Form**

If paying by bank draft, the Electronic Payment Authorization Form must be completed.

Section 1 allows the applicant to specify a payment preference for both the initial and subsequent premiums. If there is any conflict between the initial draft date selected on the application and the initial draft date selected on the Payment Form, the Payment Form date will be used.

To assist with financial matters, the applicant may select a draft date that will coincide with their Social Security deposit date as indicated in the chart below.

	Social Security Benefits Paid on
For beneficiaries who first started receiving Social Security in May 1997 or later and whose birth date falling on or between: • 1st and 10th of the month • 11th and 20th of the month • 21st and 31st of the month	 Second Wednesday Third Wednesday Fourth Wednesday
Supplement Security Income (SSI)	1st of the Month
Beneficiaries who started receiving Social Security Benefits prior to May 1997 or who are receiving both SSI and Social Security	3rd Wednesday
If date falls on weekend or holiday, payment is made prior business day	

The option is also available to draft on a specific day of the month from 1 to 28. If this option is chosen and that day falls on a weekend or holiday the draft will occur the next business day. If a preferred draft day is not selected in section 1, all subsequent premiums will be drafted/charged on effective day.

G. **Refunds**

The company will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

APPLICATION

A. Application Sections

The Medicare Supplement application consists of seven sections all of which must be completed. Please be sure to review your applications for the following information before submitting.

Section A — Proposed Insured Information

- Please complete the applicant's residence address in full.
- Please complete the applicant's date of birth and current age. Please remember age and premiums are based on the effective date, not the date the application was signed.
- Medicare card number, also referred to as the Health Insurance Claim (HIC) number, is vital for electronic claims payment
- Height/Weight — required on underwritten cases.

Section B — Plan and Premium Information

- Entire Section must be completed, indicating the plan selected, effective date, Household Discount selection, and premium amount collected. If no premium collected, indicate when initial bank draft should be processed (issue date or effective date). If neither is selected, **the first modal premium and policy fee will be drafted on or after the effective date of the policy.**

Section C— Eligibility Questions

The tobacco question must be answered for all underwritten applications. The chart below indicates whether the tobacco question must be answered for open enrollment or guaranteed issue situations.

State	Tobacco question required		State	Tobacco question required
AL	YES		NC	NO
AZ	YES		NV	YES
FL	YES		NJ	NO
GA	YES		ND	NO
ID	YES		OH	NO
IL	NO		OK	YES
IN	YES		PA	NO
IA	YES		SC	NO
KS	YES		SD	YES
KY	NO		TN	NO
LA	NO		TX	NO
MI	NO		UT	NO
MS	YES		VA	NO
MT	YES		WV	YES
NE	YES		WY	YES

- Indicate if the applicant is covered under Parts A and B of Medicare.
- Indicate if the applicant's Medicare Part A and B effective or eligibility dates.
- Indicate if the applicant is applying during a guaranteed issue period, and if so, include proof of eligibility if the answer is yes.

Section D — Health Questions

- If the applicant is applying during an open enrollment or a guarantee issue period, do not answer the health questions or prescription information.
- If applicant is not considered to be in open enrollment or a guarantee issue situation, all health questions must be answered, including the question regarding prescription medications.

NOTE: In order to be considered eligible for coverage, the initial section of the application health questions that indicate when the applicant is not eligible for coverage must be answered "No" and any "Yes" answers to the subsequent section of health questions where the applicant may be eligible for coverage must be explained and evaluated by an underwriter.

For questions on how to answer a health question, see the Health Questions section of this Guide for clarification.

- Please complete the Applicant Physician Information, including the Applicant's Primary Physician's name, address and phone number.
- If the Applicant has seen a Specialist Physician in the last 24 months, please list the Specialist's name, medical specialty, and diagnosis or reason for seeing.
- Please indicate if the Applicant has seen more than 3 Specialists in the last 24 months.

Section E – Medication History

- Note if applicant is taking any prescription or over-the-counter medications recommended by a physician, list each medication, as well as the original date prescribed, dosage and frequency, and diagnosis/condition the medication is treating.

Section F – Replacement Information

- Verify if the applicant is covered through state Medicaid program.
- If applicant is leaving a Medicare Advantage or Medicare Cost/HMO plan, complete question #3 and include the replacement notice
- If applicant is replacing another Medicare supplement policy, complete question #4 and include the replacement notice. If question #4 is answered 'yes', question 4b must also be answered 'yes' or a policy cannot be issued. The sale of more than one Medicare Supplement policy is prohibited by law.
- If applicant has had any other health insurance coverage in the past 63 days, including coverage through a union, employer plan, or other non-Medicare supplement coverage, complete question #5

Please note question #1, 2, 4, and 5 must always be answered.

B. Authorization and Certification

Signatures and dates: required by the applicant and the writing agent. All agents must be appointed in applicant's resident state and applicant's signature state before a policy can be issued. If someone other than applicant is signing the application (i.e., Power of Attorney (POA)), include copies of the papers appointing that person as the legal representative.

- POA signatures are only allowed for Medicare Supplement applications applying for guaranteed issue or open enrollment. If POA documents are over 12 months old, an affidavit signed by the POA and notarized, except where prohibited by law, is required.

- Indicate Policy Mailing Preference, all policies will be mailed directly from the Company's administrative office to the agent unless otherwise indicated on the application or as state law requires.

C. Declined Applications

Applications Will Be Declined for The Following Reasons**:**

- The applicant does not recall filling out the application.
- A family member completed the application and a family member signed the application.
- A POA or other representative signed the application when the applicant was not in a Medicare Supplement Open Enrollment or Medicare Supplement Guaranteed Issue period.
- Any "yes" answers to the medical and health questions (excluding the tobacco question).
- If, at the time the policy is to be issued, the application was taken by an agent who is not licensed and appointed, in the applicant's resident state.
- The applicant is unable or unwilling to complete the telephone interview.
- Additional forms requested by the underwriter are not submitted within the allotted timeframe.
- The applicant is taking any of the drugs listed on the Medication guideline for the condition listed (see medication list - page 23).
- If the application was submitted with a post-dated check, cash, agent or agency check, money order, traveler's check or payment from a Third-Party payor that has no family or business relationship to the applicant/insured, except where prohibited by law. Note, the same prohibitions apply to renewal premium.
- The applicant is replacing a Medicare Advantage or Medicare Cost/HMO Plan and is unable to provide proof of disenrollment from the Medicare Advantage or Medicare Cost/HMO Plan.
- An applicant cannot provide the medical condition that a prescribed medication is treating and is unable to obtain the information from their physician.

D. Applicants requesting the reason for declination

- If the reason for decline was non-medical, this information will be verbally released to both the agent and applicant.
- If the reason for decline came from information the applicant disclosed during the phone interview, the applicant will be advised verbally or be sent "the reason for decline letter" directly to the applicant only. This request can be made verbally or in writing.
- If the reason for decline came from medical records or information obtained directly from a physician the reason for the decline will be released only to a physician of the applicant's choice. This request should be in writing indicating the name, address and phone number of the physician and signed by the applicant.

E. Withdrawn Applications

An applicant can request to withdraw their application anytime during the underwriting process in writing or verbally via a recorded statement with one of our representatives. The writing agent will be contacted when notification is received indicating the applicant is withdrawing their application. The writing agent will be given 10 business days in which to try to conserve the business.

If an applicant's premium check is returned by a financial institution, the application will be processed as withdrawn (a returned check is considered written notification of the applicant's intent to withdraw their insurance application). The writing agent is not contacted about conserving the business in this situation.

A full refund of the premium submitted with a withdrawn application will be processed 7 days after the date the check was deposited (to ensure the check has cleared the bank) if the refund amount is $1,000 or less. Refunds greater than $1,000 will be held 21 days to ensure the check has cleared the financial institution. If an applicant requests the refund during this timeframe, the applicant will need to provide proof the check has cleared. The refund check and a letter confirming the application was withdrawn will be mailed to the applicant. An agent portal message will be sent to the writing agent.

If an application was submitted without premium a letter confirming the application was withdrawn will be mailed to the applicant. An agent portal message will be sent to the writing agent.

F. Not Taken Insurance Policies

Applicants who have received an insurance policy without any outstanding delivery requirements will need to provide a signed written notice of their request not to take their issued insurance policy. The request can be the returned insurance policy with a clear notation on it stating they do not wish to keep the insurance policy, or a signed letter or other written statement.

If the applicant was mailed an insurance policy with outstanding delivery requirements, and the delivery requirements are not received within the allotted timeframe, the insurance policy will be considered Not Taken and processed as such.

An applicant with a Not Taken insurance policy should be encouraged to return the insurance policy if they have not already done so.

In order to receive a full refund of premium, the request not to take the insurance policy must be either post-marked (if sent via mail) or received by the Company's administrative office (if faxed) within the 30-day free look period. A full refund of the premium for Not Taken insurance policies will be processed 7 days after the date the check was deposited (to ensure the check has cleared the financial institution) if the refund amount is $1,000 or less. Refunds greater than $1,000 we be held for 21 days to ensure the check has cleared the financial institution. If the applicant requests the refund during this timeframe, the applicant will need to provide proof the check has cleared.

HEALTH QUESTIONS

Unless an application is completed during open enrollment or a guarantee issue period, all health questions, including the question regarding prescription medications, must be answered. Each state's application contains an initial section of health questions, that if any one of those questions is answered "Yes", the applicant is not eligible for coverage. For a list of uninsurable conditions and the related medications associated with these conditions, refer to pages 21-24.

It is important to note that there are conditions and events, such as a heart attack, implantation of a pacemaker, stroke and crippling/disabling arthritis that, if the event or diagnosis occurred within the last 24 months, the applicant is ineligible for coverage. On the other hand, if it has been more than 24 months since the event or diagnosis, consideration for coverage may be given.

There are also situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition which may be an acceptable risk. Those conditions are listed in the second section of health questions for which individual consideration is given and an applicant may be eligible for coverage.

A condition typically is considered controlled if within the past 2 to 3 years there have been (1) no changes in treatment and (2) no increase in the dosage of medication. If the applicant meets those criteria and consideration of the application is desired, answer the appropriate question "Yes" and provide an explanation on the application stating how long the condition has existed and how it is being controlled. Be sure to include the names and dosages of all prescription medications. Note, the underwriting for a condition being well controlled may involve additional factors than those stated above.

Below is a list of how some of the conditions listed in individual consideration health questions will be interpreted for underwriting purposes.

A. Individual Consideration Question: Heart & Circulatory Disease

Consideration for coverage may be given to those persons who have had or have been treated for or advised to have treatment for any of the heart or circulatory conditions listed in this question provided it has been longer than 24 months since diagnosis or occurrence of the event. In addition, to verify stability, there should be no cardiac related hospitalizations within the past three years. The applicant shall also be subject to co-morbidity height and weight limits.

Below are general guidelines related to Heart and Circulatory Diseases:

Heart and Circulatory diseases is a general term that refers to a variety of acute and chronic medical conditions that affect one or more of the components of the heart or circulatory system.

Conditions that are classified as Heart and Circulatory diseases include:

Heart & Circulatory Conditions Listed on Application	
Angina	Enlarged Heart
Aortic or Cardiac Aneurysm	Heart Rhythm Disorders**
Atrial Fibrillation	Heart Valve Disease
Cardiomyopathy	Peripheral Vascular Disease
Congestive heart Failure	Peripheral Venous Thrombotic Disease
Coronary or Carotid Artery Disease	Stroke
	Transient Ischemic Attack (TIA)

Heart & Circulatory Conditions Not Listed on Application	
Adams-Stokes Disease	Myocarditis
Congenital Heart Disease	Peripheral Artery Disease
Endocarditis	Rheumatic Heart Disease
Heart Attack	
***Below are some types and descriptions of Heart Rhythm Disorders:*	
Bradycardias – an arrhythmia that makes the heart rhythm too slow	
Tachycardias – an arrhythmia that makes the heart rhythm too fast	
Bundle Branch Block (BBB) – disorders affecting the bundle branches	
Atrial Fibrillation / Atrial Flutter – an irregular heart rhythm, caused by extremely rapid and chaotic electrical impulses that are generated in the heart's atria.	

A pacemaker, defibrillator or ablation procedure in addition to drug therapy are common forms of treatment for heart rhythm disorders. Note: use of an implantable cardiac defibrillator will lead to a decline.

B. Individual Consideration Question: Degenerative Bone Disease, Spinal Stenosis, and Crippling or Disabling and Rheumatoid Arthritis

Degenerative bone disease, spinal stenosis, and crippling/disabling and rheumatoid arthritis are medical conditions determined by many factors. Some additional field underwriting questions/observations are listed below to help you determine if the application should be submitted:

- Can the applicant perform their activities of daily living such as, dressing, eating, bathing, housework and shopping without limitations? – Application can be submitted.
- Does the applicant require any assistance in walking, such as, use of a cane, walker, wheelchair, or does another person provide assistance? – Application should not be submitted.
- Is the applicant considering or been advised by a physician to have physical therapy, surgery or injections? – Application should not be submitted.
- Has the applicant received any injections or infusions within the past 24 months for arthritis or degenerative bone disease? – Application should not be submitted.
- Is the applicant taking a narcotic pain medication on a regular basis (daily or weekly) for arthritis or degenerative bone disease? – Application should not be submitted.

C. Individual Consideration Question: Mental or Nervous Disorder

Consideration for coverage may be given to those persons with a mental or nervous disorder requiring psychiatric care providing the treatment has been stable for the past 3 years. The condition is considered stable if:

- There have been no new medications added and no increases in medications for at least 3 years,
- The applicant has no more than 4 maintenance psychiatric visits per year, and
- They have not been hospitalized for this condition in the past 3 years.

D. Individual Consideration Question: Diabetes

Consideration for coverage may be given to those with well-controlled cases of high blood pressure and diabetes. **Pre-Diabetes, border-line diabetes, or those applicants taking or advised to take prescription medications to control their blood sugar will be underwritten the same as diabetes**. A case is considered well-controlled if the person is taking:

- Less than 50 units of insulin daily
- No more than two oral medications for diabetes
- No more than two medications for high blood pressure.

A combination of less than 50 units of insulin a day and one oral medication would be the same as two oral medications. In general, to verify stability, there should be no increase in the dosages of medications for at least 1 year. If more than two medications are being taken, individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower. In addition, the applicant shall be subject to co-morbidity height and weight limits.

E. Individual Consideration Question: Recent Hospitalization

Consideration for coverage may be given to those who have been hospitalized, treated at an outpatient facility, urgent care center or an emergency room within the last 12 months.

F. Uninsurable Health Conditions

Applications should not be submitted if applicant has the following conditions:

AIDS	Emphysema
Alzheimer's Disease	Kidney or Renal Dialysis
ARC	Kidney disease
Cirrhosis	Lateral Sclerosis (ALS)/Lou Gehrig's Disease
Chronic Obstructive Pulmonary Disease (COPD)	Lupus - Systemic
Other chronic pulmonary disorders to include:	Multiple Sclerosis
Chronic bronchitis	Myasthenia Gravis
Chronic obstructive lung disease (COLD)	Organ, Bone Marrow, Stem Cell Transplant
Chronic asthma	Osteoporosis with fracture
Chronic interstitial lung disease	Parkinson's Disease
Chronic pulmonary fibrosis	Senile Dementia
Cystic fibrosis	Other cognitive disorders to include
Tuberculosis	Mild cognitive impairment (MCI)
Sarcoidosis	Delirium
Bronchiectasis	Organic brain disorder
Scleroderma	Cirrhosis (of Liver)
Chronic Hepatitis	Kidney or Renal Failure/End State Renal Disease
Chronic Kidney Disease	

In addition to the above conditions, the following will also lead to a decline:

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer on a regular/continuous basis
- Asthma requiring continuous use of three or more medications including inhalers or asthma and current tobacco use
- Regular use of a narcotic medication (daily or weekly) for any condition listed on the application.
- Taking any medication that must be administered in a physician's office through injection, IV, infusion within the past two years or any that are currently scheduled or anticipated in the next 12 months
- Macular degeneration that requires or will require laser treatment or injections
- Advised to have surgery, medical tests, treatment or therapy that has not been performed
- If applicant's height/weight is in the decline column on the chart

Diabetes in conjunction with any of the following list of heart and circulatory conditions will result in a decline:

- History of stents
- History of bypass surgery
- Defibrillator
- Congestive Heart Failure (CHF)
- Enlarged Heart / Cardiomyopathy
- Coronary Artery Disease (CAD)
- Carotid Artery Disease (CAD)
- Carotid Arteries "cleaned out"
- History of a heart attack,
- Peripheral Vascular Disease (PVD)
- Peripheral Arterial Disease (PAD)
- "Blockage"
- History of an Endarterectomy
- "Plaque Build-up" / "Clogged Arteries"
- Heart Valve Disease
- Heart Valve Replacement
- History of stroke or transient ischemic attack(TIA)

G. Medication Guideline

This list is not all-inclusive. An application should not be submitted if an applicant is taking any of the following medications:

Medication	Condition	Medication	Condition
3TC	AIDS	Hydrea	Cancer
Acetate	Prostate Cancer	Hydroxyurea	Melanoma, Leukemia,
Alkeran	Cancer		Cancer
Amantadine	Parkinson's Disease	Imuran	Immunosuppression,
Apokyn	Parkinson's Disease		Severe Arthritis
Aptivus	HIV	Insulin (>50 units/day)	Diabetes
Aricept	Dementia	Interferon	AIDS, Cancer, Hepatitis
Artane	Parkinson's Disease	Indinavir	AIDS
Atripla	HIV	Invega	Schizophrenia
Avonex	Multiple Sclerosis	Invirase	AIDS
Azilect	Parkinson's Disease	Kaletra	HIV
AZT	AIDS	Kemadrin	Parkinson's Disease
Baclofen	Multiple Sclerosis	Lasix / Furosemide(>60 mg/day)	Heart Disease
BCG	Bladder Cancer	L-Dopa	Parkinson's Disease
Betaseron	Multiple Sclerosis	Letairis	Pulmonary Hypertension
Bicalutamide	Prostate Cancer	Leukeran	Cancer,
Carbidopa	Parkinson's Disease		Immunosuppression,
Casodex	Prostate Cancer		Severe Arthritis
Cerefolin	Dementia	Leuprolide	Prostate Cancer
Cognex	Dementia	Levodopa	Parkinson's Disease
Combivir	HIV	Lexiva	HIV
Comtan	Parkinson's Disease	Lioresal	Multiple Sclerosis
Copaxone	Multiple Sclerosis	Lomustine	Cancer
Crixivan	HIV	Lupron	Cancer
Cytoxan	Cancer, Severe Arthritis,	Megace	Cancer
	Immunosuppression	Megestrol	Cancer
D4T	AIDS	Mellaril	Psychosis
DDC	AIDS	Melphalan	Cancer
DDI	AIDS	Memantine	Alzheimer's Disease
DES	Cancer	Methotrexate (>25 mg/wk)	Rheumatoid Arthritis
DuoNeb	COPD	Metrifonate	Dementia
Eldepryl	Parkinson's Disease	Mirapex	Parkinson's Disease
Embrel	Rheumatoid Arthritis	Myleran	Cancer
Emtriva	HIV	Namenda	Alzheimer's Disease
Epivir	HIV	Natrecor	CHF
Epogen	Kidney Failure, AIDS	Nelfinavir	AIDS
Ergoloid	Dementia	Neoral	Immunosuppression,
Exelon	Dementia		Severe Arthritis
Fuzeon	HIV	Neupro	Parkinson's Disease
Galantamine	Dementia	Norvir	HIV
Geodon	Schizophrenia	Novatrone	Multiple Sclerosis
Gold	Rheumatoid Arthritis	Paraplatin	Cancer
Haldol	Psychosis	Parlodel	Parkinson's Disease
Herceptin	Cancer	Permax	Parkinson's Disease
Hydergine	Dementia	Prednisone (>10 mg/day)	Rheumatoid Arthritis, COPD
Prezista	HIV	Tacrine	Dementia

Medication	Condition	Medication	Condition
Prolixin	Psychosis	Teslac	Cancer
Razadyne	Dementia	Thiotepa	Cancer
Remicade	Rheumatoid Arthritis	Thorazine	Psychosis
Reminyl	Dementia	Trelstar-LA	Prostate Cancer
Remodulin	Pulmonary Hypertension	Triptorelin	Prostate Cancer
Requip	Parkinson's Disease	Trizivir	HIV
Rescriptor	HIV	Truvada	HIV
Retrovir	AIDS	Tysabri	Mutliple Sclerosis
Rebif	Multiple Sclerosis	Valcyte	CMV HIV
Reyataz	HIV	VePesid	Cancer
Rilutek	Amyotrophic Lateral Sclerosis	Videx	HIV
Riluzole	Amyotrophic Lateral Sclerosis	Vincristine	Cancer
Ritonavir	AIDS	Viracept	HIV
Sandimmune	Immunosupression	Viramune	AIDS
	Severe Arthritis	Viread	HIV
Selzentry	HIV	Zanosar	Cancer
Sinement	Parkinson's Disease	Zelapar	Parkinson's Disease
Stalevo	Parkinson's Disease	Zerit	HIV
Stelazine	Psychosis	Ziagen	HIV
Sustiva	AIDS	Ziprasidone	Schizophrenia
Symmetrel	Parkinson's Disease	Zoladex	Cancer
		Zometa	Hypercalcemia in Cancer

REQUIRED FORMS

A. Application

Only current Medicare Supplement applications may be used in applying for coverage. A copy of the completed application will be made by the Company and attached to the policy to make it part of the contract.

B. Electronic Payment Authorization Form

If premiums are paid by automatic bank draft, complete this form.

C. Replacement Form

The replacement form must be signed and submitted with the application when replacing any Medicare Supplement, Medicare Advantage or Medicare Cost/HMO plan. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application.

AMENDMENTS

An Amendment to the application will be generated for the following reasons:

- Any question left blank (a new application will be required if four or more questions are left blank)
- Any question answered incorrectly on the application (as determined in the phone interview)
- An error or unclear answer for the date of birth or plan being applied for
- Application sign date is left blank or is altered
- The "signed at" information is left blank or is incorrect
- A change made to the application is not initialed by the applicant
- Premium calculation error (if the first month's premium is to be paid via bank draft and we are unable to contact the applicant to get approval)

STATE ADDITIONAL FORM REQUIREMENTS

Additional forms specifically mandated by the states to accompany the required forms:

A. Florida

Florida Agent Certification – A signed copy must be submitted with the application.

B. Illinois

Medicare Supplement Checklist – The Checklist must be completed and submitted with the application and a copy left with the applicant.

C. Kentucky

Medicare Supplement Comparison Statement – The Comparison Statement must be completed and submitted when replacing a Medicare supplement, a Medicare Advantage or a Medicare HMO plan.

D. Ohio

The Medicare Supplement Insurance Solicitation Notice – The Solicitation Notice must be completed and submitted with the application and a copy left with the applicant.

PRIVACY AND HIPAA COMPLIANCE

The State Privacy Laws and the Health Insurance Portability and Accountability Act (HIPAA) establishes requirements and restrictions pertaining to the use and disclosure of Nonpublic Personal Information as well as Protected Health Information. CSO has a customer Privacy and Principles & Notification of Information Practices which you are required to provide to an applicant at the time of application. This notice is also available at www.cso.com.

Your adherence to federal and state laws and regulations that provide privacy protections is mandatory. CSO's expectations for your handling of CSO customer information is as set forth in your Agent Agreement with the Company.

A few Notes