Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
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MEDICARE SUPPLEMENT COVERAGE APPLICATION

SECTION I – Proposed Insured information

APPLICANT NAME *(exactly as it appears on your Medicare Health Insurance card)*

First name	**Middle initial**	**Last name**

Date of birth *(MM/DD/YYY)*	**Age** *(at Effective Date)*	**Social Security Number**

Gender *(select one)*	**Phone number(s)** *(with area code)*
☐ Male ☐ Female	*Mobile:* *Home:*

Resident address

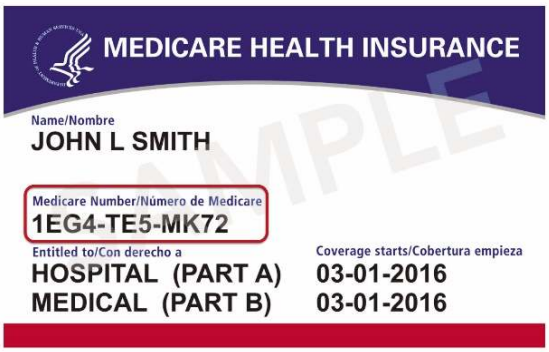
City	**State**	**ZIP code**

Mailing address *(if different from Resident address)*

City	**State**	**ZIP code**

Medicare Number *(exactly as it appears on your Medicare Health Insurance card; see below sample)*

Medicare Health Insurance card sample:



ALL PAGES OF THE APPLICATION MUST BE SUBMITTED

SECTION II – Plan and payment information

Plan	Requested policy effective date

Household premium discount

☐ Yes *(please complete the Household Discount form)* ☐ No

Modal Premium	Policy fee	Premium collected
$	$	$

Payment method *(select one):*	**Payment mode** *(select one):*
☐ Billed *(select one):*	☐ Quarterly ☐ Semi-annual ☐ Annual
☐ Bank draft *(select one):*	☐ Monthly *(bank draft only)* ☐ Quarterly ☐ Semi-annual ☐ Annual

SECTION III – Eligibility questions ***(please answer all questions)***

1. Are you covered under Medicare Part A?	☐ Yes	☐ No
If *NO*, what is your future Part A eligibility date? *(MM/DD/YYYY)*		
If *YES,* what is your Part A effective date? *(See "Coverage starts" on your Medicare Health Insurance card. MM/DD/YYYY)*		
2. Are you covered under Medicare Part B?	☐ Yes	☐ No
If *NO*, what is your future Part B eligibility date? *(MM/DD/YYYY)*		
If *YES,* what is your Part B effective date? *(See "Coverage starts" on your Medicare Health Insurance card. MM/DD/YYYY)*		
3. Have you enrolled in Medicare Part B more than once?	☐ Yes	☐ No
4. Are you applying during a guaranteed issue period? (If *YES,* you must attach your proof of eligibility to this application.)	☐ Yes	☐ No

If you are applying during an *Open Enrollment* or a *Guaranteed Issue* period, **go to SECTION VII – Replacement questions**.

If not, please proceed **to SECTION IV – Health questions**.

SECTION IV – Health questions

Please answer ALL of the following questions.

If you answer *YES* to any questions from 3 to 10 in this section, you are not eligible for coverage.

1.	Height *(feet and inches)*: Weight *(pounds)*:		
2.	Within the past twelve (12) months, have you used any tobacco or nicotine products, including: - cigarettes - cigars - pipes - vapes - chewing tobacco - nicotine gum/patches - eCigarettes	☐ Yes	☐ No
3.	- Are you bedridden or confined to a wheelchair, - do you require the assistance of a motorized mobility device, or - have you had any amputation caused by disease?	☐ Yes	☐ No
4.	Are you: - currently hospitalized, - in a nursing home or assisted living facility, - or have you been hospitalized three or more times in the past two years?	☐ Yes	☐ No
5.	Are you currently receiving any: - occupational, speech, or physical therapy, or - services from a home healthcare agency?	☐ Yes	☐ No
6.	Have you been advised by a physician to have any of the following that have not been performed: - surgery (including cataract or joint replacement surgery), - medical tests (excluding HIV/AIDS), infusions, or therapy?	☐ Yes	☐ No
7.	Have you had, been medically diagnosed with, or treated at any time for any of the following:		
	a) Cognitive or nervous system disorders: i) Parkinson's disease ii) Dementia iii) Multiple or amyotrophic lateral sclerosis iv) Muscular Dystrophy v) Alzheimer's disease vi) Any other cognitive disorder?	☐ Yes	☐ No
	b) - Acquired immune deficiency syndrome (AIDS), - AIDS related complex (ARC), or - human immunodeficiency virus (HIV) infection?	☐ Yes	☐ No
	c) - Chronic kidney disease stage 3-5, - kidney insufficiency, or - renal failure requiring dialysis?	☐ Yes	☐ No
	d) - Emphysema, - chronic obstructive pulmonary disease (COPD), - any other chronic pulmonary condition, or - any medical condition requiring the use of oxygen?	☐ Yes	☐ No
	e) - Systemic lupus, - scleroderma, or - myasthenia gravis?	☐ Yes	☐ No
	f) An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Yes	☐ No

SECTION IV – Health questions *(continued)*

g) Chronic hepatitis or cirrhosis of the liver?	☐ Yes	☐ No
h) Cardiac defibrillator implantation?	☐ Yes	☐ No
8. Have you had any of the following in the last two (2) years:		
a) - Heart attack, - cardiac angioplasty, or - bypass surgery, - stent placement or replacement?	☐ Yes	☐ No
b) Vascular angioplasty - endarterectomy, or - implantation of a pacemaker?	☐ Yes	☐ No
c) A stroke or transient ischemic attack (TIA)?	☐ Yes	☐ No
9. Have you had, been treated for, or been advised by a physician within the last two (2) years to have treatment for:		
a) Alcoholism or drug abuse?	☐ Yes	☐ No
b) - Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), - leukemia, - melanoma, - Hodgkin's disease, or - lymphoma?	☐ Yes	☐ No
c) Arthritis that restricts mobility?	☐ Yes	☐ No
10. Do you have diabetes or take medication to control your blood sugar? If *YES*, please answer each of the following questions (a to d). If *NO*, please answer each question (a to d) with '*NO*'.	☐ Yes	☐ No
a) Have you ever required or been advised to take more than fifty (50) units of insulin daily?	☐ Yes	☐ No
b) Do you take three (3) or more medications (oral or injections) to control your blood sugar?	☐ Yes	☐ No
c) Do you take four (4) or more medications to control your high blood pressure?	☐ Yes	☐ No
d) Have you been diagnosed with or treated for any of the following conditions: - peripheral vascular disease, - peripheral venous thrombotic disease, - peripheral artery disease, - kidney disease, - kidney failure, - stroke, - transient ischemic attack (TIA), - congestive heart failure, or - any heart disorder?	☐ Yes	☐ No

SECTION V – Consideration health questions

If you answer *YES* to any of the following health questions, your application will be submitted to underwriting for further review.

11. Are you currently receiving, or have you been advised to receive injections in a physician's office?	☐ Yes	☐ No
12. Have you had or been treated for or been advised by a physician to have treatment within the last two (2) years for:		
a) - Coronary artery disease, - angina, - aortic or cardiac aneurysm, - cardiomyopathy, or - congestive heart failure, - heart valve disorder, - atrial fibrillation, - other heart rhythm disorder?	☐ Yes	☐ No
b) - Peripheral artery disease, - peripheral vascular disease, or - peripheral venous thrombotic disease, - carotid artery disease?	☐ Yes	☐ No
c) - Degenerative bone disease, - spinal stenosis? - rheumatoid arthritis, or	☐ Yes	☐ No
d) Any mental or nervous disorder requiring treatment by a psychiatrist?	☐ Yes	☐ No

If you answered *YES* to any of the questions in this section (V), please provide dates and details regarding your treatment below.

SECTION VI – Medication history

Are you taking or have you taken any prescription or over-the-counter medications within the past twelve (12) months?	☐ Yes	☐ No

If you answered *YES* to the above question, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication name *(copy off pharmacy label)*:	
Date **originally** prescribed *(MM/DD/YYY)*:	
Date prescription **last filled** *(MM/DD/YYYY):*	
Dosage and frequency:	
Diagnosis/condition:	

Medication name *(copy off pharmacy label)*:	
Date **originally** prescribed *(MM/DD/YYY)*:	
Date prescription **last filled** *(MM/DD/YYYY):*	
Dosage and frequency:	
Diagnosis/condition:	

Medication name *(copy off pharmacy label)*:	
Date **originally** prescribed *(MM/DD/YYY)*:	
Date prescription **last filled** *(MM/DD/YYYY):*	
Dosage and frequency:	
Diagnosis/condition:	

ATTACH A SEPARATE SHEET IF NEEDED

SECTION VII – Replacement questions

You may be guaranteed acceptance in one or more of our Medicare supplement plans, **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.
- You had certain rights to buy such a policy.

Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS to the best of your knowledge.

1. a) Did you turn age 65 in the last six months?	☐ Yes	☐ No
b) Did you enroll in Medicare Part B in the last six months?	☐ Yes	☐ No
If *YES*, what is the effective date? *(From Medicare Health Insurance card, MM/DD/YYYY)*.		
2. Are you covered for medical assistance through the state Medicaid program? *NOTE: If you are participating in a "*Spend-Down Program*" and have not met your "*Share of Cost*", please answer* NO *to this question.*	☐ Yes	☐ No
If *YES*, please answer questions a) and b) below.		
a) Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes	☐ No
b) Do you receive any benefits from Medicaid *OTHER THAN* payment toward your Medicare Part B premium?	☐ Yes	☐ No
3. Have you had coverage from any Medicare plan other than original Medicare within the past sixty three (63) days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)	☐ Yes	☐ No
If *YES*, please answer questions a) to d) below.		

a) Name of company:	
Plan type & policy/certificate no.:	
Company telephone number:	
Coverage dates *(MM/DD/YYYY):*	*Start date:* *End date:* *If you are still covered under this plan, leave end date blank.*

b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐ Yes	☐ No
c) Was this your first time in this type of Medicare plan?	☐ Yes	☐ No
d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes	☐ No

SECTION VII – Replacement questions *(continued)*

4. Do you have another Medicare supplement policy in force?	☐ Yes	☐ No

If *YES,* please answer questions a) and b) below.

a) Name of company:	
Plan type & policy/certificate no.:	
Company telephone number:	
Issue date *(MM/DD/YYYY):*	

b) Do you intend to replace your current Medicare supplement policy with this policy?	☐ Yes	☐ No
5. Have you had coverage under any other health insurance within the past sixty three (63) days? (For example, an employer, union, or individual plan.)	☐ Yes	☐ No

If *YES,* please answer below.

Name of company	
Plan type & policy/certificate no.	
Company telephone number	
Coverage dates *(MM/DD/YYYY)*	*Start date:* *End date:* *If you are still covered under this plan, leave end date blank.*

SECTION VIII – Agent certification

THIS SECTION IS FOR AGENTS ONLY – agents will list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

2. List policies sold in the past five *(5)* years which are no longer in force.

Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

SECTION VIII – Agent certification *(continued)*

Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

SECTION IX – Important statements to be read by the applicant

- 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 Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 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 suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

SECTION X – Electronic and/or telephonic instructions

In order to process your signature, the Company requests your authorization to act on electronic and/or telephonic instructions from the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss, or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine and these procedures have been followed (check one).

☐ I authorize the Company to act on electronic and/or telephonic instructions.

☐ I DO NOT authorize the Company to act on electronic and/or telephonic instructions.

The company also requests your authorization to deliver statements and other documents electronically, **such as by email or Internet**. (check one).

☐ I authorize the Company to electronically deliver statements and other documents. I do have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address.

☐ I DO NOT authorize the Company to electronically deliver statements and other documents.

SECTION XI – Signature and final acknowledgments

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that:

(a) **the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant.**

(b) **oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.** The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at:

State	Applicant's signature	Date

Agent writing number	Agent's signature	Date

Policy mailing preference: ☐ Mail to Agent ☐ Mail to Applicant