Home Office: Jefferson City, MO
Administration: P.O. Box 10874
Clearwater, Florida 33757-8874

LUMICO LIFE INSURANCE COMPANY

Lumico life insurance

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION I. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare Card)*		
First Name	Middle Initial	Last Name
Resident Address		Phone *(with area code)*
City		Date of Birth (*MM/DD/YYYY)*
State	Zip Code	Age (*at Effective Date)*
Mailing Address (if different from Resident Address)		Email Address
City		Male ☐ Female ☐
State	Zip code	Social Security Number
Medicare Card Beneficiary Identification Number		

SECTION II. PLAN AND PREMIUM INFORMATION

Plan	Requested Policy Effective Date	Household Premium Discount Yes ☐ No ☐ *If you answered Yes, please complete the Household Discount form.*
Modal Premium $		Policy Fee $
Premium Collected $		Payment Method: Bank Draft ☐ Direct Bill ☐
Payment Mode: Monthly ☐ (Bank Draft ONLY)	Annual ☐	Semi-Annual ☐ Quarterly ☐

SECTION III. PLEASE ANSWER ALL ELIGIBILITY 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? (*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? (*MM/DD/YYYY*) _____

SECTION III. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS (continued)	
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 proof of eligibility).	Yes ☐ No ☐

SECTION IV. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION VII.
If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
If you answer YES to any of the following questions 3 – 10, you are not eligible for coverage.

1. Height (*Feet and inches*):_____ Weight (*Pounds*):_____

2. Within the past 12 months, have you used any tobacco or nicotine products, including cigarettes, cigars, eCigarettes, vape, chewing tobacco, pipe, or nicotine gum/patch? Yes ☐ No ☐

3. Are you bedridden, confined to a wheelchair, or 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 are you currently using the services of a home healthcare agency? Yes ☐ No ☐

6. Have you been advised by a physician to have surgery (including cataract or joint replacement surgery), medical tests, infusions, or therapy that has not been performed? Yes ☐ No ☐

7. At any time, have you had, been medically diagnosed with, or treated for any of the following:

   a. Parkinson's disease, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia, or 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, or kidney insufficiency, or renal failure requiring dialysis? Yes ☐ No ☐

   d. Emphysema, chronic obstructive pulmonary disease (COPD), or 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 ☐

   g. Chronic hepatitis or cirrhosis of the liver? Yes ☐ No ☐

   h. Cardiac defibrillator implanted? Yes ☐ No ☐

SECTION IV. HEALTH QUESTIONS (continued)

8. Within the past two years, have you had any of the following:

   a. Heart attack, cardiac angioplasty, bypass surgery, or 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. Within the past two years have you had, been treated for, or been advised by a physician 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. If you have diabetes or take medication to control your blood sugar, please answer each of the following questions (a-d); otherwise, answer each question 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, 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 review.

11. Are you currently receiving, or have you been advised to receive injections in a physician's office? Yes ☐ No ☐

12. Within the past two years have you had or been treated for or been advised by a physician to have treatment for:

   a. Coronary artery disease, angina, aortic or cardiac aneurysm, cardiomyopathy, congestive heart failure, heart valve disorder, atrial fibrillation, or other heart rhythm disorder? Yes ☐ No ☐

   b. Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, or carotid artery disease? Yes ☐ No ☐

   c. Degenerative bone disease, spinal stenosis, or rheumatoid arthritis? Yes ☐ No ☐

   d. Any mental or nervous disorder requiring treatment by a psychiatrist? Yes ☐ No ☐

You must explain any yes answers above and provide dates and details.

SECTION VI. MEDICATION HISTORY

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

If YES, 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	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION VII. REPLACEMENT QUESTIONS

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.

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 ☐

   (c) If YES, indicate your effective date (*MM/DD/YYYY*). _____

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)
   If YES, answer (a) – (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 63 days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.) Yes ☐ No ☐

   If YES, answer (a) – (g) below.

   (a) Name of Company .....

   Plan Type & Policy/Certificate No .....

   Company Telephone Number .....

   Coverage Dates (*MM/DD/YYYY*): START DATE _____

   (if you are still covered under this plan, leave end date blank) END DATE _____

   (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 ☐

   If YES, have you received a copy of the replacement notice? Yes ☐ No ☐

   (c) Reason for termination/disenrollment? .....

   (d) Planned date of termination/disenrollment? (*MM/DD/YYYY*) _____

   (e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐

   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐

   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

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

   If YES, answer (a) – (d) 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 or Medicare select policy/certificate with this policy? Yes ☐ No ☐

   (c) Indicate termination date (*MM/DD/YYYY*). _____

   (d) Have you received a copy of the replacement notice? Yes ☐ No ☐

SECTION VII. REPLACEMENT QUESTIONS (continued)

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐

If YES, answer (a) – (c) below.

(a) Name of Company

Plan Type & Policy/Certificate No

Company Telephone Number

Coverage Dates (*MM/DD/YYYY*): START DATE

(if you are still covered under this plan, leave end date blank) END DATE

(b) Reason for termination/disenrollment?

(c) Planned date of termination/disenrollment (*MM/DD/YYYY*)?

SECTION VIII. AGENT CERTIFICATION

Agents shall 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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

SECTION IX. IMPORTANT STATEMENTS TO BE READ BY 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.

Authorization is requested by the Company 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.

Authorization is requested by the Company for the electronic delivery of statements and other documents (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. CERTIFICATION

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; and (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 knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

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