S.USA LIFE INSURANCE COMPANY, INC.
SBLI USA LIFE INSURANCE COMPANY, INC.

Fax Application Transmittal Cover Sheet

Important:

- Use this form for **NEW** application submissions.
- Only applications paying the initial premium by bank draft should be faxed.
- DO NOT collect premium with an application that is being faxed.
- All applications submitted with this form must be written by the same agent.
- Please use one transmittal per application.
- Do not mail in applications/forms once you have faxed them, original copies should be maintained in case of fax transmission problems.
- Complete all Agent information in the box below.
- DO NOT fax documents or corrections requested by Underwriting to the number below (2nd applications, replacement forms or other additional documents).

Fax **New applications** and corresponding documents ***ONLY*** to: 1-855-227-7849

Agent Name: _____ Agent Writing # _____

Phone Number: _____ Fax Number: _____

Total number of pages being faxed (including cover sheet): _____

Forms sequence:

- ☐ Application
- ☐ Replacement form (if applicable)
- ☐ Other state specific required forms (if applicable)
- ☐ Guaranteed Issue documentation (if applicable)
- ☐ Creditable Coverage documentation (if applicable)
- ☐ Signed bank draft authorization
- ☐ Copy of a voided check or deposit slip on a separate sheet of paper

Applicant First & Last Name	Plan Applied For:	Initial Premium Amount to be drafted

All application questions should be directed to the Underwriting Department at 1-855-228-3771

S.USA Life Insurance Company, Inc.

New Business Pack for
Medicare Supplement Insurance

OHIO

S.USA Life Insurance Company, Inc.

Speed up the processing by double checking the following:

❒ **Applicant's Personal information completed**
(DOB, Gender, SSN, Medicare number/dates)

❒ **All dates completed**
(Effective Dates, signature dates)

❒ **Agent Solicitation Notice forms completed**
(Signed & dated and submitted with application)

❒ **Replacement forms completed**
(Signed & dated and submitted with application)

❒ **Household Discount Form completed, if applicable**
(Signed and dated by both Agent and Client)

❒ **Premium and payment information completed**
(Modal Premium listed, Bank Information complete)

❒ **Prior Coverage information completed**
(Carrier, plan, start & end dates)

Medicare Supplement
Administrative Office:
P. O. Box 10853, Clearwater, FL 33757-8853
1-855-228-3771

S.USA Life Insurance Company, Inc.

Application for Medicare Supplement Coverage

INCOMPLETE INFORMATION MAY DELAY PROCESSING.

Application for ☐ New Business ☐ Reinstatement

SECTION 1: APPLICANT INFORMATION – PLEASE ANSWER ALL QUESTIONS COMPLETELY

Name (First/Middle/Last)	
Residence Address	
City	State Zip
Home Phone No (_____) _____ - _____ area code	Age as of Eff Date _____ Date of Birth ____/_____/_____ MM DD YYYY
☐ Male ☐ Female	Social Security No: - -
Email Address	Medicare Card Number

SECTION 2: PLAN / PREMIUM PAYMENT INFORMATION

Medicare Supplement Plan Requested:	Requested Effective Date: _____/_____/_____
Are you applying for the Household Premium Discount?	Yes ☐ No ☐ If Yes, please complete the Household Discount form.
Premium $	Policy Fee $
Premium Collected $	Initial Bank Draft $

Payment Mode: *select one* Monthly ☐ (Bank Draft ONLY) Annual ☐ Semi-Annual ☐ Quarterly ☐

Payment Method: *select one* Bank Draft ☐ Direct Bill ☐

SECTION 3: MEDICARE INFORMATION – PLEASE ANSWER ALL QUESTIONS COMPLETELY

To the Best of Your Knowledge:

1. Are you covered under Medicare Part A? ☐ Yes ☐ No
   If "YES," what is your Part A effective date? _____/_____/_____
   If "NO," what is your future Part A eligibility date? _____/_____/_____
2. Are you covered under Medicare Part B? ☐ Yes ☐ No
   If "YES," what is your Part B effective date? _____/_____/_____
   If "NO," indicate date you plan to enroll. _____/_____/_____

SECTION 3: MEDICARE INFORMATION (CONTINUED) – PLEASE ANSWER ALL QUESTIONS COMPLETELY.

3.	Is this your first time enrolling in Medicare Part B?	☐ Yes ☐ No
4.	Will you turn 65 within the next six months?	☐ Yes ☐ No
5.	Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).	☐ Yes ☐ No
6.	Are you applying during an Open Enrollment period?	☐ Yes ☐ No
	If YES, are you replacing Creditable Coverage? If so, please attach Creditable Coverage letter.	☐ Yes ☐ No

If you do not have six months of Creditable Coverage, any health condition for which medical advice or treatment was recommended by a medical professional or received from a medical professional within a six (6) month period preceding the Effective Date of the coverage you have applied for is subject to the Pre-Existing Condition limitation. Please list those medical conditions in the space provided below.

SECTION 4: MEDICAL QUESTIONS – PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

If you qualify for this coverage during Open Enrollment or a Guaranteed Issue period, you are not required to answer the questions in Section 4.

If you answer YES to any of questions 3 – 14, you are not eligible for coverage.

1.	Height: _____ feet_____ inches Weight: _____Pounds	
2.	Have you used tobacco in any form in the past 12 months?	☐ Yes ☐ No
3.	Are you currently confined or scheduled for admission to a hospital, assisted living or nursing facility, or are you receiving home health care, hospice or physical therapy, or do you require oxygen?	☐ Yes ☐ No
4.	Are you currently bedridden or require assistance of a wheelchair, walker or motorized mobility aid?	☐ Yes ☐ No
5.	Do you require assistance with bathing, toileting, eating, dressing or transferring?	☐ Yes ☐ No
6.	Within the past 12 months have you received treatment from a pain clinic or have you had any pain medication administered through injection or infusions or are you prescribed narcotic medication(s) for chronic pain (*excluding flu, vitamin B-12 & allergy shots*)?	☐ Yes ☐ No
7.	Have you EVER been diagnosed, treated or been advised by a physician to have treatment for:	
	a. Alzheimer's Disease, Dementia, Cognitive or Organic Brain Disorder?	☐ Yes ☐ No
	b. Amyotrophic Lateral Sclerosis (ALS)/Lou Gehrig's Disease, or Huntington's Disease?	☐ Yes ☐ No
	c. Cirrhosis of the Liver, Chronic Hepatitis (excluding Hepatitis A), or Multiple Sclerosis?	☐ Yes ☐ No
	d. Chronic Kidney Disease, Kidney Failure, Renal Insufficiency, or Kidney Disease requiring Dialysis?	☐ Yes ☐ No
8.	Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?	☐ Yes ☐ No
9.	Within the past three (3) years, have you been diagnosed, treated or been advised by a physician to have treatment for:	
	a. Internal Cancer, Leukemia, Lymphoma, Multiple Myeloma, or Malignant Melanoma?	☐ Yes ☐ No
	b. Unrepaired Aneurysm, Blood Disorder, or Anemia requiring Blood Transfusions?	☐ Yes ☐ No
	c. Crohn's Disease or Ulcerative Colitis?	☐ Yes ☐ No
	d. Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or other Chronic Pulmonary Disorder (*this includes Asthma, if treatment requires the use of more than two (2) Inhalers/Nebulizers)?*	☐ Yes ☐ No
10.	Within the past two (2) years have you been diagnosed, treated or been advised by a physician to have treatment for:	
	a. Degenerative Bone Disease, Osteoporosis with related Fractures, Spinal Stenosis, Crippling/Disabling or Rheumatoid Arthritis or have you been advised to have a Joint Replacement?	☐ Yes ☐ No
	b. Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, or Connective Tissue Disorder?	☐ Yes ☐ No
	c. Alcoholism or Drug Abuse?	☐ Yes ☐ No
	d. Major Depressive Disorder, Schizophrenia, Bipolar or Paranoid Disorder?	☐ Yes ☐ No
	e. Any terminal medical condition?	☐ Yes ☐ No

SECTION 4: MEDICAL QUESTIONS (CONTINUED):

11. Has any surgery, medical test, treatment or therapy been advised by a physician but not completed (*including cataract surgery; excluding routine preventative screenings and HIV/AIDS tests)*? ☐ Yes ☐ No

12. Have you been confined to a hospital more than two (2) times in the last two (2) years and/or have you been treated in an Emergency Room more than two (2) times in the last six (6) months? ☐ Yes ☐ No

13. Have you had or been advised by a physician to have an organ transplant or have you had an amputation due to a disease? ☐ Yes ☐ No

14. Within the past five (5) years have you been diagnosed, treated or been advised by a physician to have treatment for Heart, Coronary or Carotid Artery Disease, Cardiomyopathy, Peripheral Vascular Disease, Congestive Heart Failure or ANY type of Heart Failure? ☐ Yes ☐ No

15. Within the past five (5) years have you been diagnosed, treated or been advised by a physician to have treatment for:
    a. Stroke? ☐ Yes ☐ No
    b. Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
    c. Heart Attack? ☐ Yes ☐ No
    d. Heart Rhythm Disorder? ☐ Yes ☐ No
    e. Angioplasty, Heart or Circulatory Surgery? ☐ Yes ☐ No
    f. Pacemaker or Defibrillator? ☐ Yes ☐ No

If you answered YES to any of questions a-f above, please answer questions i-v below: (any "yes" answer to questions i-iv. you are not eligible for coverage)

    i. In the last two (2) years have you had an increase in dosage or frequency of your medication that you are taking for this condition(s)? ☐ Yes ☐ No
    ii. In the last five (5) years have you had any hospitalizations related to this condition(s)? ☐ Yes ☐ No
    iii. In the last five (5) years have you had or been advised to have any surgery, procedure(s) or test(s) for this condition(s)? ☐ Yes ☐ No
    iv. Do you take more than 2 blood pressure medications? ☐ Yes ☐ No
    v. Do you take a blood thinner? ☐ Yes ☐ No

If you answered YES to question v (blood thinner), please answer question vi below: (if you answer "yes" to this question, you are not eligible for coverage)

    vi. *Have you had any change in dosage in the last two (2) years?* ☐ Yes ☐ No

16. Do you have Diabetes or are you prescribed medications to regulate your blood sugar? ☐ Yes ☐ No

If you answered YES to question 16, please answer questions a-h below: (any "yes" answer to questions a–g, you are not eligible for coverage)

    a. Do you require insulin for your Diabetes? ☐ Yes ☐ No
    b. Was your most recent AIC reading greater than 7.0? ☐ Yes ☐ No
    c. Do you currently take more than two (2) oral medications to control your Diabetes? ☐ Yes ☐ No
    d. Have your Diabetic medications been increased in the past 24 months (*excludes formulary changes)*? ☐ Yes ☐ No
    e. Do you have Peripheral Vascular Disease? ☐ Yes ☐ No
    f. Do you have Neuropathy, Nephropathy or Retinopathy? ☐ Yes ☐ No
    g. Do you have ANY Heart Disorder (excluding High Blood Pressure)? ☐ Yes ☐ No
    h. Do you have High Blood Pressure (HBP)? ☐ Yes ☐ No

If you answered YES to question h (High Blood Pressure), please answer questions i and ii below: (any "yes" answer, you are not eligible for coverage)

    i. Do you currently take more than two (2) medications for High Blood Pressure? ☐ Yes ☐ No
    ii. Was your most recent blood pressure reading greater than 150/85? ☐ Yes ☐ No

SECTION 5: MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If "YES," please list the drug, date originally prescribed, frequency, dosage, and the condition for which you are taking the medication below.	☐ Yes ☐ No

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

SECTION 6: 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. Please mark Yes or No below with an "X".

To the best of your knowledge:

1. (a) Did you turn 65 in the last 6 months? ☐ Yes ☐ No

   (b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

   (c) If yes, what is the effective date? _____

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. ☐ Yes ☐ No

   IF YES,

   (a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

3. (a) If 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), fill in your start and end dates. If you are still covered under this plan, leave "END" blank.

   START __/__/__ END __/__/__

   If yes, with what company?

   Company_____

   Company telephone number _____ Policy number _____

   (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

4. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

   (b) If so, with which company? _____

   With which plan? _____

   And what paid-to-date do you have? _____

   (c) If so, 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 63 days? (For example, an employer, union, or individual plan) ☐ Yes ☐ No

   (a) If yes, with what company and what kind of policy? _____

   Company telephone number_____ Policy number_____

   (b) What are the dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START __/__/__ END __/__/__

SECTION 7: OTHER INSURANCE IF APPLICABLE

Producers shall list any other health insurance policies/certificates they have sold to the applicant.

a) List policies/certificates sold which are still in force.

Name of Company _____

Policy/Certificate Number _____

Description of Benefits _____

Effective Date of Coverage / /

b) List policies/certificates 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 / /

SECTION 8: 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 9: AUTHORIZATION – PLEASE READ AND SIGN BELOW

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to provide to S.USA Insurance Company, Inc., its affiliates, service providers, agents and representatives, or its reinsurers (collectively, "S.USA"), any such information. I understand that I am authorizing S.USA to receive my health information and prescription drug usage history. The released information will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with S.USA. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to S.USA *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying S.USA in writing at their Medicare Supplement Administrative Office: P.O. Box 10853, Clearwater, Florida 33757-8853. I understand that such revocation will not have any effect on actions S.USA prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

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, 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*."

*******IMPORTANT*******

If your policy is issued during your Open Enrollment period, it will contain up to a six (6) month waiting period on pre-existing conditions unless you provide proof you are replacing Creditable Coverage. If you qualify as an eligible person, any waiting period will be waived for the period of time Creditable Coverage was provided.

Dated at _____ on ____ / ____ / _____ _____

State MM DD YR Applicant's Signature

I certify that during an interview with the proposed applicant, I have truly and accurately recorded in the application the information supplied by the applicant.

PRODUCER NUMBER / (STAMP)	Signature of Licensed Producer
Signature Date	Printed Name of Licensed Producer

Mail Policy To: ☐ Insured ☐ Producer

ADDITIONAL INFORMATION: SECTION 5 – MEDICATION HISTORY (CONTINUED – IF APPLICABLE)	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	/ /
Frequency and Dosage	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	/ /
Frequency and Dosage	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	/ /
Frequency and Dosage	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	/ /
Frequency and Dosage	
Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS IF APPLICABLE

S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050
Administrative Office: P.O. Box 10853, Clearwater, Florida 33757-8853

AGENT MEDICARE SUPPLEMENT INSURANCE SOLICITATION NOTICE

- The person making this solicitation is an Ohio-licensed insurance agent.
- You may verify that the agent is licensed by contacting The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215, toll-free at 1-800-686-1526; TDD (614) 644-3745, www.ohioinsurance.gov.
- The insurer issuing the Medicare supplement insurance policy is S.USA Life Insurance Company, Inc. You may contact the insurance company at P.O. Box 10853, Clearwater, Florida 33757-8853; toll-free: 1-855-228-3771 9 a.m. – 4 p.m. ET, Monday – Friday
- Neither the insurance company nor the agent/broker making this solicitation have any connection or affiliation with, and are not in any way sponsored by, the federal or state government, the Social Security Administration, the Centers for Medicare and Medicaid services, or the Department of Health and Human Services.

If you decide to purchase a Medicare supplement health insurance plan, you have the option of paying the premium directly to the insurance company. This is to confirm that the undersigned agent has read this notice and provided a copy of this notice to the Medicare-eligible beneficiary whose signature appears below on this _____ day of _____, _____.

Signature Insurance Agent/broker: _____

Printed name: _____

Ohio License Number: _____

Address: _____
street address city state zip code

Telephone: _____

Signature Medicare-eligible beneficiary: _____

Printed name: _____

Instructions: Agent must read and provide one copy of this notice to Medicare-eligible beneficiary at the time of solicitation for a Medicare supplement insurance policy/certificate. The second copy of this notice must be submitted with the application. The agent and beneficiary must sign both copies, acknowledging the notice was presented both orally and in writing to the Medicare beneficiary.

COMPLETE AND SUBMIT THIS COPY WITH THE APPLICATION

S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050
Administrative Office: P.O. Box 10853, Clearwater, Florida 33757-8853

AGENT MEDICARE SUPPLEMENT INSURANCE SOLICITATION NOTICE

- The person making this solicitation is an Ohio-licensed insurance agent.
- You may verify that the agent is licensed by contacting The Ohio Department of Insurance, 50 West Town St., Suite 300, Columbus, Ohio 43215, toll-free at 1-800-686-1526; TDD (614) 644-3745, www.ohioinsurance.gov.
- The insurer issuing the Medicare supplement insurance policy is S.USA Life Insurance Company, Inc. You may contact the insurance company at P.O. Box 10853, Clearwater, Florida 33757-8853; toll-free: 1-855-228-3771 9 a.m. – 4 p.m. ET, Monday – Friday
- Neither the insurance company nor the agent/broker making this solicitation have any connection or affiliation with, and are not in any way sponsored by, the federal or state government, the Social Security Administration, the Centers for Medicare and Medicaid services, or the Department of Health and Human Services.

If you decide to purchase a Medicare supplement health insurance plan, you have the option of paying the premium directly to the insurance company. This is to confirm that the undersigned agent has read this notice and provided a copy of this notice to the Medicare-eligible beneficiary whose signature appears below on this _____ day of _____, _____.

Signature Insurance Agent/broker: _____

Printed name: _____

Ohio License Number: _____

Address: _____
street address city state zip code

Telephone: _____

Signature Medicare-eligible beneficiary: _____

Printed name: _____

Instructions: Agent must read and provide one copy of this notice to Medicare-eligible beneficiary at the time of solicitation for a Medicare supplement insurance policy/certificate. The second copy of this notice must be submitted with the application. The agent and beneficiary must sign both copies, acknowledging the notice was presented both orally and in writing to the Medicare beneficiary.

COMPLETE AND LEAVE THIS COPY WITH THE APPLICANT

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

S.USA LIFE INSURANCE COMPANY, INC

Medicare Supplement Administrative Office
P. O. Box 10853, Clearwater, Florida 33757-8853

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

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

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

STATEMENT TO APPLICANT BY AGENT:

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

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. S.USA Life Insurance Company, Inc. will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

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

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

Signature of Agent, Broker or Other Representative

_____

Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

_____ _____

Applicant’s Signature Date

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

S.USA LIFE INSURANCE COMPANY, INC

Medicare Supplement Administrative Office
P. O. Box 10853, Clearwater, Florida 33757-8853

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

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

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

STATEMENT TO APPLICANT BY AGENT:

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

_____ Additional benefits.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. S.USA Life Insurance Company, Inc. will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.

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

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

Signature of Agent, Broker or Other Representative

_____

Name and Address of Agent

The above “Notice to Applicant” was delivered to me on:

_____ _____

Applicant’s Signature Date

S.USA LIFE INSURANCE COMPANY, INC.

P.O. Box 1050, Newark, NJ 07101-1050
Administration Office: P.O. Box 10853
Clearwater, Florida 33757-8853

Medicare Supplement Household Discount Form

Applicant Name:	Applicant Social Security Number:

To qualify for the Household Discount, the applicant must meet the following criteria below. Both boxes below must be checked in order to qualify.

☐ I am currently married and residing in a Household* with my legal spouse named below; or I have been residing in a Household* with the person named below for at least the last 12 months.

AND

☐ My legal spouse or additional resident has an existing Medicare supplement policy, or is applying for such a policy, with S.USA Life Insurance Company, Inc.

The Household Discount will be removed if the other Medicare Supplement policyholder chooses to terminate his or her Medicare Supplement policy or he or she no longer resides with you.

* Household is defined as a condominium unit, a single family home, or an apartment unit within an apartment complex. Assisted Living Facilities, Group Homes, Adult Day Care facilities and Nursing Homes, or any other health residential facilities are not included in the definition of Household.

Legal Spouse or Additional Resident Name:			
Address:	City:	State:	Zip Code:
Last Four Digits of Social Security Number:		Date of Birth (mm/dd/yyyy):	
Relationship to Applicant:			
Existing S.USA Medicare Supplement Policy Number (if applicable):			

Agent/Applicant Signature:

By signing this form I certify that I qualify for the household discount by meeting the criteria listed above.

_____

Agent's Signature Date

_____

Applicant's Signature Date

PROSPERITY LIFE GROUP℠

SBLI USA Life Insurance Company, Inc.
S.USA Life Insurance Company, Inc.
Shenandoah Life Insurance Company
(Each the "Company")
Members of the Prosperity Life Group

Administrative Office: P.O. Box 10853, Clearwater, FL 33757-8853

ELECTRONIC FUND TRANSFER AUTHORIZATION FORM

Insured Name: _____ Insurance Policy Number: _____

The accountholder must sign and date this authorization below.

As a convenience to me, I hereby authorize the Company to make withdrawals from my account with the Financial Institution identified below for the purpose of paying insurance premium on the above-listed policy. I agree that the withdrawals made on such Financial Institution shall constitute due notice of premiums being due upon the policy. The withdrawals reflected on my bank statement will constitute a receipt. **I understand that written notification to discontinue OR to make a change to an EFT withdrawal must be received in our Administrative Office five (5) days prior to the next withdrawal date.** I understand that if any account withdrawal is not paid upon presentation and any premiums due on the policy are not paid within the time stipulated in the policy, insurance coverage may lapse or may be terminated by the Company. **I understand that this authorization is revocable only upon receipt by the Company of a written notice of revocation.**

Section 1 – Indicate below when you would like your account drafted.

Many of our customers have requested the option to pay their premiums on the same day they receive Social Security or SSI payments. The options below allow you to select the date that best fits your needs. You may select any option regardless of whether or not you receive Social Security.

Initial Premium Payment: **(choose one)**

- ☐ Same as subsequent payment date selected below, on or after the requested Effective Date
- ☐ On the Policy Issue Date
- ☐ Paid by enclosed check

Subsequent Premium Payments: **(choose one)**

- ☐ 1st day of the Month
- ☐ 2nd Wednesday of the Month
- ☐ 3rd day of the Month
- ☐ 3rd Wednesday of the Month
- ☐ 4th Wednesday of the Month

NOTE: If one of the above dates falls on a weekend or holiday, deduction will be on ***prior*** business day.

- ☐ Other, please specify a day of the month from 1 to 28 _____ (if this date falls on a weekend or holiday, deduction will be on ***next*** business day)

Section 2 – Select one of the payment options.

☐ **Checking** (***Please attach a voided check.***)

☐ **Savings** (***Please ask the Financial Institution to verify this EFT will be accepted and that the information provided is correct. Not all Financial Institutions will acknowledge an EFT debit to a savings account.***)

Branch/Bank Name: _____

Routing Number: _____ Account Number: _____

Section 3 – Complete name and address as shown on account.

Accountholder Name: _____

Relationship to Insured: _____

Address/City/State/Zip: _____

Section 4 – Please sign and date.

Signature: _____ Date: _____

Administrative Office: P.O. Box 10853, Clearwater, FL 33757-8853

INITIAL PREMIUM RECEIPT

ALL CHECKS FOR INITIAL PREMIUM MUST BE MADE PAYABLE TO S.USA LIFE INSURANCE CO. INC.

Do not make check payable to agent or leave the payee blank.

Received from _____(*Proposed Insured)* an application for a Medicare Supplement plan with S.USA Life Insurance Co. Inc. and a check in the amount of $_____ for the initial premium on such policy.

If for any reason, the Company should decline to issue the policy, the above amount will be refunded in full.

NOTICE TO APPLICANT: If for any reason the Company determines that you are not eligible for coverage, no insurance or temporary or interim insurance of any kind will be effective. Insurance is not effective until the policy applied for has been issued.

Date:_____

Agent Name (print):_____

Agent Signature:_____

Complete Receipt and Leave with Applicant at time of application.