SHENANDOAH LIFE INSURANCE COMPANY

New Business Pack for Medicare Supplement Insurance

New Jersey

NJ 0120

Shenandoah Life Insurance Company

Improve processing time by verifying the following:

Validate MACRA eligibility type:

- Pre-MACRA = Medicare Part B eligibility date prior to 01/01/2020; or
- Post-MACRA = Newly Medicare Eligible and their 65th birthday is after 01/01/2020; Plans C & F are **NOT** available

(**Refer to CMS.gov for additional information regarding MACRA**)

Verify the following is complete:

- Applicant's personal information:
  - DOB, gender, SSN, Medicare number and dates;
- All dates: effective dates, signature dates;
- Replacement form: termination reason, signed and dated;
- Premium and payment information: Modal Premium, Bank information;
- Prior coverage information: carrier, plan, start and end dates

Important Notice:

EFT Premium Payments will be drafted upon issuance.

PREMIUM BILLING AND DRAFT DATE ADVISORY:

INITIAL PREMIUMS ARE DRAFTED ON THE DAY THE POLICY IS ISSUED. The ongoing premium **due date** coincides with the same date of the month as the **effective date**. For example, if the effective date is June 15th, the policy premium is due on the 15th of each month. To help protect the integrity of the policy, we recommend the draft date and the effective (due) date be the same. If a draft date other than the effective date is chosen, please note the following:

- Recurring premiums are drafted in the month in which they become due. This means any draft date other than the effective date will occur either **before** or **after** the actual due date.
- Consumer protections such as the policy grace period and timely communication are based on the premium **due date**, not the date the premium is paid.

For example, if the premium due date is the 15th and a draft date of the 5th is chosen, payment will occur 10 days early. If a draft date of the 27th is chosen, payment will occur 12 days into the 31 day grace period.

We strongly recommend making the draft date coincide with the policy effective date.

Overnight Address: 2650 McCormick Drive, Clearwater, FL 33759

Producer Name________________________ Producer Number_____________

Administrative Office:
P.O. Box 14558 Clearwater, FL 33766-4558
(855) 406-9085

Application for Medicare Supplement Coverage

INCOMPLETE INFORMATION MAY DELAY PROCESSING.

Application for ☐ New Business ☐ Reinstatement (If applying for reinstatement, SKIP Sections 4 and 5.)

SECTION 1: Plan/Premium Payment Information (to be completed by Producer)

NOTE: For ALL sections, ONLY complete the Applicant B information if second applicant is to be insured.

APPLICANT	**APPLICANT B**
Medicare Supplement Plan Requested: ☐ A ☐ C* ☐ D ☐ F* ☐ G ☐ N * Plans C and F are only available for those whose Medicare Part A eligibility date is before 1/1/2020.	Medicare Supplement Plan Requested: ☐ A ☐ C* ☐ D ☐ F* ☐ G ☐ N * Plans C and F are only available for those whose Medicare Part A eligibility date is before 1/1/2020.
Requested Effective Date ______________________________	Requested Effective Date ______________________________
Mail Policy To: ☐ Insured ☐ Producer	Mail Policy To: ☐ Insured ☐ Producer
Calculated Premium (include policy fee; HHD) $ ________ - $ ________ + $ ________ = $ ________ premium HHD policy fee total	Calculated Premium (include policy fee; HHD) $ ________ - $ ________ + $ ________ = $ ________ premium HHD policy fee total
Select Premium Payment Option: ☐ Annual direct ☐ ACH Annual ☐ Semi-annual direct ☐ ACH Semi-annual ☐ Quarterly direct ☐ ACH Quarterly ☐ ACH Monthly (direct monthly not available)	Select Premium Payment Option: ☐ Annual direct ☐ ACH Annual ☐ Semi-annual direct ☐ ACH Semi-annual ☐ Quarterly direct ☐ ACH Quarterly ☐ ACH Monthly (direct monthly not available)

SECTION 2: Applicant Information – PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Applicant	**Applicant B**
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_________)_________ - _________ (area code)	Home Phone No (_________)_________ - _________ (area code)
Current Age _________ Date of Birth ____________________ mo/day/ yr	Current Age _________ Date of Birth ____________________ mo/day/ yr
☐ Male ☐ Female State of Birth__________________	☐ Male ☐ Female State of Birth__________________
Social Security No ____________________________	Social Security No ____________________________
E-mail Address	E-mail Address
Height: Ft ________ In ________ Weight: Lbs __________	Height: Ft ________ In ________ Weight: Lbs __________

SECTION 2: Applicant Information (continued) – PLEASE ANSWER ALL QUESTIONS COMPLETELY.	
Medicare Number (if known) ____________________	Medicare Number (if known) ____________________

SECTION 3: HOUSEHOLD PREMIUM DISCOUNT INFORMATION.		
You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.	**Applicant**	**Applicant B**
1. Does an individual with whom you have continuously resided for the last 12 months either have an existing Medicare supplement plan issued after January 1, 2014 with, or are applying for coverage with Shenandoah Life Insurance Company?	☐ Yes ☐ No	☐ Yes ☐ No
2. If you answered “YES” to Question 1 above, please fill out the following information listing up to 3individuals and their primary place of residence. This information does not need to be completed for Applicant B.		
Name (First/Middle/Last)		
Policy Number		
Street Address		
City/State/Zip		
Name (First/Middle/Last)		
Policy Number		
Street Address		
City/State/Zip		
Name (First/Middle/Last)		
Policy Number		
Street Address		
City/State/Zip		

SECTION 4: PLEASE ANSWER ALL QUESTIONS COMPLETELY.		
Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**?	**Applicant** ☐ Yes ☐ No	**Applicant B** ☐ Yes ☐ No
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you covered under Medicare Part B?	☐ Yes ☐ No	☐ Yes ☐ No
3. Will you turn 65 within the next six months?	☐ Yes ☐ No	☐ Yes ☐ No
4. Did you enroll in Medicare Part B in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
Please complete the following:		
Medicare Part A Effective Date:	___/____/____	___/____/____
Medicare Part B Effective Date:	___/____/____	___/____/____
Are you applying for coverage because you have been recently diagnosed with or are currently being treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 5: FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

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 certificate, or that you had certain rights to buy such a policy or certificate, 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" with an "X" to the questions below.**

To the Best of Your Knowledge:	**Applicant**	**Applicant B**
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company, and what plan do you have?		

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date / /	Issue Date / /

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date.__________ (Applicant) / __________ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No

If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? If "YES," please complete the following:	☐ Yes ☐ No	☐ Yes ☐ No
Start Date:	___/____/____	___/____/____
End Date:	___/____/____	___/____/____
(a) 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	☐ Yes ☐ No
(b) **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No

(c) Reason for termination/disenrollment?________________ (Applicant) / ________________ (Applicant B)

(d) Planned date of termination/disenrollment?________________ (Applicant) / ________________ (Applicant B)

(e) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No
4. 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	☐ Yes ☐ No
(a) If "YES," with what company and what kind of policy/certificate? (List below.)		

Applicant		**Applicant B**	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.
START__________ END__________ (Applicant) / START__________ END__________ (Applicant B)

(c) Reason for termination/disenrollment?________________ (Applicant) / ________________ (Applicant B)

(d) Planned date of termination/disenrollment?________________ (Applicant) / ________________ (Applicant B)

5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES,"	☐ Yes ☐ No	☐ Yes ☐ No
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 5: FOR YOUR PROTECTION (Continued)

6. 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.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

(b) List policies/certificates sold in the past five (5) years which are no longer in force.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 6 and GO TO SECTION 7.

Underage Coverage: **Plans C and D** are available for qualified consumers aged 50 – 64 who are eligible for Medicare by reason of disability.

Open Enrollment: You are eligible for Guaranteed Acceptance in **Plan C** if your Medicare Part B effective date is prior to 1/1/2020 and you apply:

- within six months of enrollment in Medicare Part B; or
- within six months beginning with the month in which a retroactive determination of eligibility for Medicare is made.

You are eligible for Guaranteed Acceptance in **Plan D** if:

- your Medicare Part B effective date is prior to 1/1/2020 and you apply within six months of enrollment in Medicare Part B and you are not covered by any other Medicare Supplement Plan; or
- your Medicare Part B effective date is on or after 1/1/2020 and you apply within 12 months of enrollment in Medicare Part B.

SECTION 6: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answers "YES" to any of the following questions 1-16, that person is not eligible for coverage.

	Applicant	**Applicant B**
1. Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed with or treated for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed with or treated for Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, or Cirrhosis?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been diagnosed with or treated for Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been diagnosed with or treated for Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
6. 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	☐ Yes ☐ No
7. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	☐Yes ☐ No	☐ Yes ☐ No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	☐ Yes ☐ No	☐ Yes ☐ No
9. Do you have an implanted cardiac defibrillator?	☐ Yes ☐ No	☐ Yes ☐ No
10. Within the past two years have you been treated for degenerative bone disease, spinal stenosis, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	☐ Yes ☐ No	☐ Yes ☐ No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
13. Have you been hospital confined three or more times in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
15. Do you have diabetes that has ever required more than 50 units of insulin daily?	☐ Yes ☐ No	☐ Yes ☐ No
16. If you have diabetes, do you have any of the following conditions: retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), stroke, or kidney disease? If you do not have diabetes, this question should be answered "NO".	☐ Yes ☐ No	☐ Yes ☐ No
17. Have you used tobacco in any form in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
18. 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 and the condition in the following table.	☐ Yes ☐ No	☐ Yes ☐ No

SECTION 6 (Continued)		
Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	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	

IF ADDITIONAL SPACE IS REQUIRED SEE PAGE 8

SECTION 7: PLEASE READ AND SIGN BELOW

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 coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION 7: PLEASE READ AND SIGN BELOW (continued)

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Shenandoah Life Insurance Company.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. I authorize any medical professional, hospital, clinic, medical care institution, Pharmacy Benefit Manager (PBM), insurer or reinsurer, the MIB, Inc., consumer reporting agency, employer, relative, friend or neighbor to disclose to SHENANDOAH, its reinsurers, and, except for the MIB, Inc., any consumer reporting agency acting on behalf of SHENANDOAH, medical and other information pertaining to me. The information that may be disclosed includes information relating to employment; other insurance coverage; past and present physical, mental, drug and/or alcohol conditions; character; habits; avocations; finances; general reputation; credit or other personal characteristics. I authorize SHENANDOAH, or its reinsurers, to make a brief report of my personal health information to MIB. A photocopy or other electronic image of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed. I understand that I have the right to receive a copy of this Authorization and Acknowledgment. I understand that this Authorization and Acknowledgment may be revoked at any time, subject to the rights of an individual who acted in reliance on the Authorization and Acknowledgment prior to notice of the revocation.

I acknowledge and agree that a copy of all information which I provide, including Protected Health Information, will be provided to the other applicant as a part of any issued Policy.

Dated at ___________________________, on ___________________, _____ ____
City State Month Day Year Applicant's Signature

Dated at ___________________________, on ___________________, _____ ____
City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application.
I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

____
(Signature of Licensed Producer)

____
PRODUCER NUMBER / (STAMP)

ADDITIONAL INFORMATION: SECTION 6 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #18		
Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	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	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

ELECTRONIC FUNDS TRANSFER AUTHORIZATION – Request for Preauthorized Withdrawal

Applicant Name: ________________________ **Accountholder Name** (if different) __________________________

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, **THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY WHEN YOUR POLICY IS ISSUED.**

I authorize Shenandoah Life Insurance Company to withdraw funds from my account for the initial and/or renewal premiums due and request that my financial institution honor the preauthorized electronic funds transfers. Premium variances may occur for various reasons and I understand that premium amounts may differ. I agree that the Institution's rights shall be the same as if it were a check drawn and signed by me and withdrawals reflected on my bank statement constitute a receipt. I further agree that if any withdrawal fails or is disallowed, neither the Institution nor Shenandoah Life Insurance Company or its Affiliates shall be under any liability whatsoever.

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 contract, insurance coverage may lapse or may be terminated. This authorization shall continue until I provide you notification at least ten (10) business days prior to the next withdrawal date.

PREMIUM BILLING AND DRAFT DATE SELECTION

Custom draft dates are available. However, **for the policyholder's protection and the integrity of the policy, we strongly recommend preserving the draft date that coincides with the policy effective date.**

If a draft date other than the effective date is selected, please note the following:

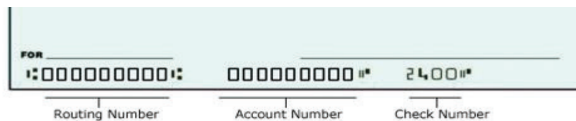
- Consumer protections such as the policy grace period and timely communication are based on the premium due date, not the date the premium is paid.
- The ongoing premium due date coincides with the same date of the month as the effective date. For example, if the effective date is June 15th, the policy premium is due on the 15th of each month.
- Recurring premiums are drafted in the month in which they become due. This means any draft date other than the effective date will occur either before or after the actual due date.

  For example, if the premium due date is the 15th and you choose a draft date of the 5th, your payment occurs 10 days early. If you choose a draft date of the 27th, your payment occurs 12 days into your 31-day grace period.

☐ **Custom Draft Date:** Please withdraw the premium on the ____ of the month (1-28).
*If a custom draft date is not selected, the draft date will remain the date that coincides with the effective date.

Check one: Checking ☐ To ensure accuracy, please attach a voided check.
Savings ☐ For a savings account, please ask your financial institution to verify that this EFT will be accepted and that the information below is correct for this request.

This verification is necessary as not all financial institutions will acknowledge EFT debits from a savings account.



Financial Institution Name:	Financial Institution Address:	Financial Institution Phone #:

Transit Routing # (from left side of check):	Account # (from right side of check):
Accountholder Name (Print):	Accountholder Relationship to Insured:
Accountholder Address:	Accountholder Phone #:

X____ _____/_____/_______
Authorized Signature as Shown on Account Date

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

ELECTRONIC FUNDS TRANSFER AUTHORIZATION – Request for Preauthorized Withdrawal

Applicant B Name: ________________________ **Accountholder Name** (if different) ________________________

IMPORTANT: When choosing to pay initial premium by Automated Bank Account Withdrawal, **THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY WHEN YOUR POLICY IS ISSUED.**

I authorize Shenandoah Life Insurance Company to withdraw funds from my account for the initial and/or renewal premiums due and request that my financial institution honor the preauthorized electronic funds transfers. Premium variances may occur for various reasons and I understand that premium amounts may differ. I agree that the Institution's rights shall be the same as if it were a check drawn and signed by me and withdrawals reflected on my bank statement constitute a receipt. I further agree that if any withdrawal fails or is disallowed, neither the Institution nor Shenandoah Life Insurance Company or its Affiliates shall be under any liability whatsoever.

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 contract, insurance coverage may lapse or may be terminated. This authorization shall continue until I provide you notification at least ten (10) business days prior to the next withdrawal date.

PREMIUM BILLING AND DRAFT DATE SELECTION

Custom draft dates are available. However, **for the policyholder's protection and the integrity of the policy, we strongly recommend preserving the draft date that coincides with the policy effective date.**

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- Recurring premiums are drafted in the month in which they become due. This means any draft date other than the effective date will occur either before or after the actual due date.

  For example, if the premium due date is the 15th and you choose a draft date of the 5th, your payment occurs 10 days early. If you choose a draft date of the 27th, your payment occurs 12 days into your 31-day grace period.

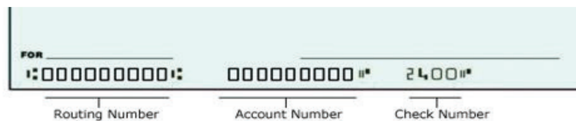
☐ **Custom Draft Date:** Please withdraw the premium on the ____ of the month (1-28).

*If a custom draft date is not selected, the draft date will remain the date that coincides with the effective date.

Check one: Checking ☐ To ensure accuracy, please attach a voided check.

Savings ☐ For a savings account, please ask your financial institution to verify that this EFT will be accepted and that the information below is correct for this request.

This verification is necessary as not all financial institutions will acknowledge EFT debits from a savings account.



Financial Institution Name:	Financial Institution Address:	Financial Institution Phone #:

Transit Routing # (from left side of check):	Account # (from right side of check):
Accountholder Name (Print):	Accountholder Relationship to Insured:
Accountholder Address:	Accountholder Phone #:

X______________________________________ _____/_____/_______

Authorized Signature as Shown on Account Date

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

INVESTIGATIVE CONSUMER REPORT PRE-NOTIFICATION

As part of our procedure for processing your initial application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics and mode of living, except as may be related directly or indirectly to your sexual orientation. You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon furnishing proper identification, you have the right to make a written request within a reasonable period of time to inspect and/or receive a copy of the report and/or to receive additional, detailed information about the nature and scope of this investigation. For this information you may write to the Administrative Office, P.O. Box 14558, Clearwater, FL, 33766-4558. This notice is in compliance with the Fair Credit Reporting Act (Public Law 91-508).

Note: Within 60 days of the date of this application you will be notified as to whether or not this application has been accepted or else be given the reason for any further delay.

MIB, INC. PRE-NOTIFICATION

Information regarding your insurability will be treated as confidential. Shenandoah Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Shenandoah Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: Shenandoah Life Insurance Company

Received from ___________________________________ *(Proposed Insured)* an application for a Medicare Supplement plan with Shenandoah Life Insurance Company (the Company) and $ _________ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.

___________________________________	_______________________________	_____________
Producer's Name (Please Print)	*Producer's Signature*	*Date*

LEAVE WITH APPLICANT

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

HIPAA Compliant Authorization for Release of Health-Related Information

Records and information obtained will be disclosed to Shenandoah Life Insurance Company so that it can: 1) evaluate my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

By signing this authorization, I authorize any and all who are involved in my care, diagnosis or treatment (including, but not limited to, medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, pharmacy benefit managers, the MIB, Inc., the Veterans Administration, other insurance companies and other medically related facilities) to release any and all medical records and information (including, but not limited to, patient histories, progress notes, test results, X-rays, pharmacy records and other diagnostic information) to be exchanged between Shenandoah Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I understand that the information in my health/medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV). It may also include, but not be limited to, information about behavioral or mental health services, alcohol abuse, drug abuse, psychiatric and psychological disorders, heart disease, pharmacy prescriptions, sexually transmitted diseases, hepatitis, and Sickle Cell Anemia.

I authorize Shenandoah Life Insurance Company, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by Shenandoah Life Insurance Company and may no longer be protected by federal privacy laws. I understand Shenandoah Life Insurance Company may report information to MIB, Inc. or to other insurance companies to which I have or may apply. I understand this Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Shenandoah Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. I understand a photocopy or other electronic image of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Shenandoah Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

______________________________________	______________________________________
Name of Proposed Insured (please Print)	*Name of Proposed Insured B (please Print)*
______________________________________	______________________________________
Signature of Proposed Insured	*Signature of Proposed Insured B*
______________________________________	______________________________________
Date	*Date*

RETURN TO COMPANY

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

PRODUCER CERTIFICATION

I the undersigned insurance producer certify:

THAT I have taken an application for:

Applicant:	Applicant B:
Medicare Supplement	Medicare Supplement
☐ Plan A	☐ Plan A
☐ Plan C	☐ Plan C
☐ Plan D	☐ Plan D
☐ Plan F	☐ Plan F
☐ Plan G	☐ Plan G
☐ Plan N	☐ Plan N

Offered by **SHENANDOAH LIFE INSURANCE COMPANY**,

to ____ (Applicant(s)),

THAT I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT I am a licensed producer of this insurance company and have given a company receipt for an initial premium in the amount
of $ ______________ , which has been paid to me by

☐ Check ☐ ACH (Check appropriate method of payment)

THAT I have clearly explained that any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

______________________________ Date

______________________________ Signature of Producer

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

______________________________ Name of Agency

______________________________ Signature of Applicant

______________________________ Address of Producer or Agency

______________________________ Signature of Applicant B, if applying

______________________________ Phone Number

RETURN TO COMPANY

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage

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 Shenandoah Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the 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 ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE

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 reasons:

❒ 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. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. 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 any 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

____
PRINTED Name and Address of Issuer, Agent, or Broker

____
Applicant's Signature

____
Signature of Applicant B, if applying

____
Date

RETURN TO COMPANY

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- ❒ 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. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
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Signature of Agent, Broker or other Representative

____
PRINTED Name and Address of Issuer, Agent, or Broker

____
Applicant's Signature

____
Signature of Applicant B, if applying

____
Date

LEAVE WITH APPLICANT

SHENANDOAH LIFE INSURANCE COMPANY

Administrative Office: P.O. Box 14558, Clearwater, FL 33766-4558

FAX TO: **1-855-414-1098**

FOR USE WITH EFT PREMIUM APPLICATIONS ONLY

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Date:	Pages (Total # of Pages including coversheet):
Applicant Name(s):	
Producer Name:	
Producer Number or NPN:	
Producer Phone Number:	
Producer Fax Number:	
Producer Email Address:	

Comments: ____

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