SHENANDOAH LIFE INSURANCE COMPANY

UNDERWRITING

GUIDELINES

For Agent Use Only – Not For Use With Consumer

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Addresses for Mailing New Business and Delivery Receipts

When mailing or shipping your new business applications, be sure to use the appropriate address below

Administrative Office Mailing Information

Mailing Address	Overnight/Express Address	Claims
Shenandoah Life Insurance Company	Shenandoah Life Insurance Company	Shenandoah Life Insurance Company
Administrative Office	Administrative Office	Claims
PO Box 14558	2650 McCormick Dr., Suite 200T	PO Box 14459
Clearwater, FL 33766-4558	Clearwater, FL 33759	Clearwater, FL 33766-4459

FAX Number for New Business - ACH Applications: 1-855-414-1098

Questions: 1-855-406-9085

Introduction

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare supplement insurance policies. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. To ensure we accomplish this goal, the producer or applicant will be contacted directly by underwriting if there are any problems with an application.

Policy Issue Guidelines

All applicants must be covered under Medicare Part A and Part B on the effective date of the policy. Policy issue is state specific. The applicant's state of residence controls the application, forms, premium and policy issue. If an applicant has more than one residence, the state where taxes are filed should be considered as the state of residence. Please refer to your introductory materials for required forms specific to your state.

MACRA

Plan Changes under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") – *Effective January 1, 2020*

MACRA is the largest scale change to the American health care system following the Affordable Care Act in 2010. The biggest impact for agents selling Medicare Supplement is that starting January 1, 2020, Medicare Supplement plans sold to individuals who are newly eligible for Medicare will not be allowed to cover the Part B deductible. Because of this**, starting on January 1, 2020, Plans C and F can no longer be sold to individuals who are newly eligible for Medicare**. This prohibition applies in all states, including waiver states.

"Newly eligible" means those individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease (ESRD) on or after January 1, 2020. This means that to be ineligible to purchase Plan C or F, an individual must BOTH have turned 65 on or after January 1, 2020 AND first become Medicare eligible on or after that date. If an individual becomes Medicare eligible before January 1, 2020 based on disability or ESRD status, OR turns 65 before January 1, 2020, whether eligible for Medicare on that date or not, they would not be considered "newly eligible" under MACRA and can buy a Plan C or F when they are entitled to Medicare Part A and enrolled in Part B.

Current enrollees (those eligible for Medicare prior to January 1, 2020) who already have Plan C or F (including the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, will be able to keep that plan and may continue to buy Plans C and F beyond January 1, 2020.

Since Plans C and F will no longer be available for "newly eligible" Medicare beneficiaries, Plans D and G will be the designated Guaranteed Issue plans for these individuals. Since Plan F High Deductible cannot be sold to "newly eligible" persons, a new Plan G High Deductible has been created. Starting January 1, 2020, the new Plan G High Deductible will be available to both newly eligible and current Medicare beneficiaries.

Because CMS plans to impose penalties for any policy that is issued incorrectly, it is imperative that, starting January 1, 2020, agents address this issue by verifying date of Medicare eligibility before completing an application, using the following guidelines:

- If the individual was born on December 31, 1954 or before – they became eligible for Medicare before January 1, 2020 and have a right to purchase a Medicare Supplement Plan C or Plan F.
- If the individual was born on January 1, 1955 or after – they became age eligible for Medicare on or after January 1, 2020 and cannot purchase a Medicare Supplement Plan C or Plan F unless they became eligible for Medicare as a result of disability or ESRD on or before January 1, 2020 (see below).
- Individuals who qualify for Medicare as a result of disability or ESRD must have qualified on or before January 1, 2020 to be able to purchase Plan C or F; those qualifying on or after January 1, 2020 cannot purchase a Medicare Supplement Plan C or F.

The following chart displays what is covered under the various plans and who is eligible for which plans as of January 1, 2020:

Benefits	Plans Available to All Applicants								Plans Available ONLY to those first eligible before 01/01/2020	
	A	B	D	G / G[1]	K	L	M	N	C	F / F[1]
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
							✓	copays apply[3]		
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2019][2]					$[5560][2]	$[2780][2]				

[1]Plans F and G also have a high deductible option which require first paying a plan deductible of $[2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

[2]Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

[3]Plan N pays 100% of the Part B coinsurance, except for a copayment of up to $20 for some office visits and up to a $50 copayment for emergency room visits that do not result in an inpatient admission.

Open Enrollment

To be eligible for Open Enrollment, an applicant must be at least 64 ½ years of age (in most states) and be within six months of his/her enrollment in Medicare Part B. Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month Open Enrollment period beginning the first of the month in which the applicant turns 65.

During this period, we cannot deny insurance coverage, place conditions on a policy or charge more premium due to past medical conditions. Proof of coverage under Medicare Part B is required for applicants who are outside the six months of enrollment in Medicare when turning 65. This includes individuals who have postponed enrollment in Medicare Part B at age 65 as well as applicants who are under age 65 and qualify due to disability. Proof of coverage under Medicare Part B includes either a copy of the Medicare Card or the letter from CMS acknowledging when medical benefits begin under Medicare. Proof of the Open Enrollment right needs to be submitted with the application.

Some states require that Medicare supplement open enrollment be offered to individuals under age 65. Refer to the chart below for details.

States with Under Age 65 Requirements

Georgia	All Plans are available. Open Enrollment if applied for within six months of Part B enrollment.
Illinois	All Plans are available. Open Enrollment if applied for within six months of Part B enrollment.
Delaware	All Plans are available. Open Enrollment if applied for within six months of Part B enrollment.
Kansas	All Plans are available. Open Enrollment if applied for within six months of Part B enrollment.
Kentucky	No Open Enrollment. All Plans are underwritten. Guaranteed Issue is available only if a person has an employer sponsored group plan or a Medicare Advantage plan that is being terminated or no longer available. Not all plans are available under Guaranteed Issue.
Maryland	Plan A is available. Open Enrollment if applied for within six months of Part B enrollment.
Mississippi	All Plans are available. Open enrollment if applied for within six months of Part B enrollment.
New Jersey	Plan C available to people age 50-64. Open Enrollment if applied for within six months of Part B enrollment.
North Carolina	Plans A, F & G are available. Open enrollment if applied for within six months of Part B enrollment.
Pennsylvania	All Plans are available. Open Enrollment if applied for within six months of Part B enrollment.
Tennessee	All Plans are available. Open Enrollment if applied for within six months of Part B enrollment. Open Enrollment is also available for six months to persons no longer having access to alternative forms of health insurance coverage due to termination or action unrelated to individual status, conduct, or failure to pay premium, or persons being involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of Social Security Act. Alternative forms of health insurance coverage include accident and sickness policies, employer sponsored group health coverage or Medicare Advantage plans.
Texas	Plans A is available. Open Enrollment if applied for within six months of Part B enrollment.

† *Effective January 1, 2020, Plans C and F are not available to "newly eligible"; please refer to page 4.*

Selective Issue

Applicants over the age of 65, or under age 65 in the states listed above, and at least six months beyond enrollment in Medicare Part B and not applying during a qualified Guaranteed Issue period will be selectively underwritten. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any health questions are answered "Yes," the applicant is not eligible for coverage. Applicants will be accepted or declined. Applications signed by a Power of Attorney will not be accepted for Selective (Underwritten) Issue.

If the Application is signed by a Power of Attorney, a properly signed and executed Power of Attorney document must be submitted with the application. Specifically, the document should give the Power of Attorney the following authorities:

- Financial/Banking authority – allows the POA to conduct financial transactions (pay premium)
- Insurance authority – allows the POA to enter into insurance contracts (sign application)
- Healthcare authority – allows the POA to make decisions and discuss healthcare issues

There may be additional items that will need to be verified. For example, if more than one person is given the Power of Attorney, is there a given order as to who is first? If the first person named is not the person who signed the application, why is the first person named not serving as the POA? When is the POA to be effective? If the POA will become effective upon written certification of disability or mental incompetence, then we would need a copy of the written certification of disability or lack of competence. We will not be able to process an application that is signed by a Power of Attorney without the proper documentation and explanations needed.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Coverage will be declined for those applicants who are outside the established height and weight guidelines. Health information, including answers to health questions on applications and claims information, is confidential and is protected by state and federal privacy laws. Accordingly, Shenandoah Life Insurance Company does not disclose health information to any non- affiliated insurance company without authorization.

Application Dates

- **Open Enrollment** – Up to six months prior to the month the applicant turns age 65 (including West Virginia).
- **Underwritten Cases** – Up to 60 days prior to the requested coverage effective date.
- **Individuals** – Individuals whose employer group health plan coverage is ending can apply up to 3 months prior to the requested effective date of coverage.

Coverage Effective Dates

Coverage will be made effective as indicated below:

1. Between age 64 ½ and 65 – The first of the month the individual turns age 65.
2. All Others – Application date or date of termination of other coverage, whichever is later.
3. Effective date cannot be the 29th, 30th or 31st of the month.

Replacements

A "replacement" takes place when an applicant wishes to exchange an existing Medicare supplement policy/certificate from Shenandoah Life Insurance Company (internal) or another company (external), for a newer or different Medicare supplement/ Select policy. Internal replacements (in most instances known as a plan change) are processed the same as external replacements, requiring a fully-completed application. Shenandoah Life Medicare supplement policies with effective dates prior to January 1, 2014 are not eligible for an internal plan change.

A policy owner wanting to apply for a non-tobacco Plan must complete a new application and qualify for coverage.

If an applicant has had a Medicare supplement/Select policy issued by Shenandoah Life Insurance Company within the last 60 days, any new applications will be considered to be a replacement application. If more than 60 days has elapsed since prior coverage was in force, then applications will follow normal underwriting rules.

All replacements involving a Medicare supplement, Medicare Select or Medicare Advantage Plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application. The replacement cannot be requested on the exact same coverage and exact same company.

The replacement Medicare supplement policy cannot be issued in addition to any other existing Medicare supplement, Select or Medicare Advantage Plan.

Reinstatements

When a Medicare supplement policy has lapsed and it is within 60 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements. Renewal commission rates will continue based on the policy's duration.

When a Medicare supplement policy has lapsed and it is more than 60 days beyond the last paid to date, the coverage cannot be reinstated. The client may, however, apply for new coverage. All underwriting requirements must be met before a new policy can be issued.

Medicare Select to Medicare Supplement Conversion Privilege

Policy owners covered under a Medicare Select Plan issued after January 1, 2014 with Shenandoah Life Insurance Company may decide they no longer wish to participate in our hospital network. Coverage may be converted to one of our Medicare supplement Plans not containing network restrictions. We will make available any Medicare supplement policy offered in their state that provides equal or lesser benefits. A new application must be completed; however, evidence of insurability will not be required if the Medicare Select policy has been in force for at least six months at the time of conversion.

Telephone Interviews

Random telephone interviews with applicants will be conducted on underwritten cases. Please be sure to advise your clients that we may be calling to verify the information on their application.

Pharmaceutical Information

Shenandoah Life Insurance Company has implemented a process to support the collection of pharmaceutical information for underwritten Medicare supplement applications. In order to obtain the pharmaceutical information as requested, please be sure to include a completed "Authorization to Release Confidential Medical Information (HIPAA)" form with all underwritten applications. This form can be found in the New Business Pack. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This additional information will not be solely used to decline coverage.

Policy Delivery Receipt

Based on state-specific requirements, a policy delivery receipt may be required. If a policy delivery receipt is required, it will be included in the policy package and a copy must be returned to our New Business office.

Guaranteed Issue Rights

If the applicant(s) falls under one of the Guaranteed Issue situations outlined below, proof of eligibility must be submitted with the application.

The situations listed below can also be found in the Guide to Health Insurance.

Note: All Plans we offer are not available Guaranteed Issue.

Guaranteed Issue Situation	Client has the right to buy
Client is in the original Medicare Plan and has an employer group health Plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending. *Note: In this situation, state laws may vary.*	Medigap Plan A, B, C, F, K or L that is sold in client's state by any insurance company. If client has COBRA coverage, client can either buy a Medigap policy/certificate right away or wait until the COBRA coverage ends.
Required supporting documentation could be a dated letter from either the employer or group carrier including the Client's name, type of coverage, coverage-end date, and termination reason.	
Client is in the original Medicare Plan and has a Medicare SELECT policy/certificate. Client moves out of the Medicare SELECT Plan's service area. Client can keep the Medigap policy/certificate or he/she may want to switch to another Medigap policy/certificate.	Medigap Plan A, B, C, F, K or L that is sold by any insurance company in client's state or the state he/she is moving to.
Required supporting documentation could be a dated letter from the SELECT carrier including the Client's name, type of coverage, coverage-end date, and termination reason.	
Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy/certificate coverage otherwise ends through no fault of client.	Medigap Plan A, B, C, F, K or L that is sold in client's state by any insurance company.
Required supporting documentation could be a dated letter from the carrier including the Client's name, type of coverage, coverage-end date, and termination reason.	

† *Effective January 1, 2020, Plans C and F are not available to "newly eligible"; please refer to page 4.*

Group Health Plan Proof of Termination

Proof of Involuntary Termination: If applying for Medicare supplement, Underwriting cannot issue coverage as Guaranteed Issue without proof that an individual's employer coverage is no longer offered. The following is required:

- Complete the Other Health Insurance section on the Medicare supplement application; and
- Provide a copy of the termination letter; showing date of and reason for termination, from the employer or group carrier.

Proof of Voluntary Termination: Under the state specific voluntary terminations scenarios, the following proof of termination is required along with completing the Other Health Insurance section on the Medicare supplement application:

- Certificate of Group Health Plan Coverage – In New Mexico, Oklahoma and Virginia, provide proof of change in benefits from employer or group carrier.

Guaranteed Issue Rights for Voluntary Termination of Group Health Plan

Note: All Plans we offer are not available Guaranteed Issue.

State	Qualifies for Guaranteed Issue
KS	No conditions – always qualifies.
IN, NJ, OH, PA, TX	If the employer sponsored plan is primary to Medicare.
IA	If the employer sponsored plan's benefits are reduced, but does not include a defined threshold.
NM, VA, WV	If the employer sponsored plan's benefits are reduced substantially.

For purposes of determining GI eligibility due to a Voluntary Termination of an employer sponsored group welfare plan, a reduction in benefits will be defined as any increase in the insured's deductible amount or their coinsurance requirements (flat dollar co-pays or coinsurance %). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for GI eligibility. This definition will be used to satisfy NM, VA and WV requirements. Proof of coverage termination is required.

Guaranteed Issue Rights for Loss of Medicaid Qualification

***Note**: All Plans we offer are not available Guaranteed Issue.*

State	Guaranteed Issue Situation	Client has the right to buy
KS	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Any Medigap plan offered by any issuer.
TN	Client, age 65 and older covered under Medicare Part B, enrolled in Medicaid (TennCare) and the enrollment involuntarily ceases, is in a Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.
	Client, under age 65, losing Medicaid (TennCare) coverage has a six-month Open Enrollment period beginning on the date of involuntary loss of coverage.	Any Medigap plan offered by any issuer.
TX	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with the notice of termination and ending 63 days after the termination date.	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer; except that persons under 65 years of age, it is a policy which has a benefit package classified as Plan A.

† *Effective January 1, 2020, Plans C and F are not available to "newly eligible"; please refer to page 4.*

Medicare Advantage ("MA")

Medicare Advantage ("MA") Annual Election Period

General Election Periods for Medicare Advantage	Timeframe	Allows for
Annual Election Period ("AEP")	Oct. 15th – Dec. 7th of every year	• Enrollment selection for a MA Plan • Disenroll from a current MA Plan • Enrollment selection for Medicare Part D
Medicare Advantage Open Enrollment Period (OEP)	Jan. 1st – Mar. 31st of every year	• MA enrollees to disenroll from any MA plan and return to Original Medicare • Switch from one Medicare Advantage Plan to another The MA OEP does not provide an opportunity to: • Switch from Original Medicare to a Medicare Advantage Plan • Switch from one Medicare Prescription Drug Plan to another • Join, switch or drop a Medicare Medical Savings plan • The Medicare Advantage Open Enrollment Period is not synonymous with the Open Enrollment Period provided for Medicare Supplement Plans.

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local State Health Insurance Assistance Program ("SHIP") office for direction.

Replacing a Medicare Advantage Plan

Enrollment in Medicare supplement insurance does NOT automatically disenroll an applicant from a Medicare Advantage plan. Applicants should contact their current insurer or 1-800-Medicare to see if they are eligible to disenroll, and to disenroll if they are able. They may choose to disenroll from their Medicare Advantage plan by enrolling in a stand-alone prescription drug plan if they are able to do so. Medicare Advantage and Medicare supplement coverage cannot overlap, and there should be no gap in coverage, so request a plan effective date to coincide with the date existing coverage ends.

Note: A copy of the applicant's MA Plan's termination notice is needed if applying for Guaranteed Issue.

Medicare Advantage Proof of Disenrollment

If applying for a Medicare supplement, Underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare Advantage, the MA Plan must notify the member of his/her Medicare supplement Guaranteed Issue rights.

Voluntarily disenrolling during AEP or OEP and not eligible for Guaranteed Issue

The section concerning the Medicare Advantage program should be answered completely:

- Stating when the Medicare Advantage program started;
- Leaving the "END" date blank, since the applicant is still covered;
- Confirming the applicant's intent to replace the current MA coverage with this new Medicare Supplement policy;
- Confirming the receipt of the replacement notice;
- Stating the reason for the termination/disenrollment;
- Completing the planned date of termination/disenrollment;
- Specifying whether this was the first time in this type of Medicare plan (MA);
- Specifying whether there had been previous Medicare Supplement coverage; and
- Answering whether that previous Medicare Supplement coverage is still available.

If the applicant is applying during the Medicare Advantage Annual Enrollment Period (AEP), and all of the above information is provided, we will **NOT** require proof of termination from the Medicare Advantage provider. ***It is the applicant's responsibility to disenroll from the Medicare Advantage coverage during either the AEP or OEP.*** Please note that the CMS guidelines Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare advises that if the client joins a Medicare Advantage Plan, he/she cannot be sold a Medigap policy unless the coverage under the Medicare Advantage Plan will end before the effective date of the Medigap policy.

If an individual is requesting Guaranteed Issue or disenrolling outside AEP/OEP

1. The section concerning the MA program should be answered completely, as stated above; and

2. Send a copy of the applicant's MA Plan's disenrollment/termination notice with the application. This is especially important if the applicant is claiming a Guaranteed Issue right based on any situation as outlined in the CMS guidelines Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

Please note: All plans are not available as Guaranteed Issue in most situations.

For any questions regarding MA disenrollment eligibility, contact your SHIP office or call 1-800- MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

Guaranteed Issue Rights With Respect to Medicare Advantage Disenrollment

The situation listed below can also be found in the Guide to Health Insurance.

Note: All Plans we offer are not available Guaranteed Issue.

Guaranteed Issue Situation	Client has the right to
Client's MA Plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the Plan's service area	Buy a Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company. Client must switch to original Medicare Plan.
Required supporting documentation could be a dated letter from the MA carrier including the Client's name, coverage-effective date, coverage-end date, and termination reason.	
Client joined a MA Plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to original Medicare	Buy any Medigap Plan that is sold in the client's state by any insurance company.
Required supporting documentation could be a dated letter from the MA carrier including the Client's name, coverage-effective date, coverage-end date, and termination reason.	
Client dropped his/her Medigap policy/certificate to join an MA Plan for the first time, has been in the Plan less than 1 year and wants to switch back	Obtain client's Medigap policy/certificate back if that carrier still sells it. If his/her former Medigap policy/certificate is not available, the client can buy a Medigap Plan A, B, C, F, K or L that is sold in his/her state by any insurance company.
Required supporting documentation could be a dated letter from the previous Medicare Supplement carrier including the Client's name, plan, and coverage-end date, along with a statement that this plan is no longer available. A dated letter from the MA carrier including the Client's name, coverage-effective date and coverage-end date may also be required.	
Client leaves an MA Plan because the company has not followed the rules or has misled the client	Buy Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company.
Required supporting documentation is a dated letter from CMS confirming that the client was misled and the effective date that the MA Plan has been terminated.	

† *Effective January 1, 2020, Plans C and F are not available to "newly eligible"; please refer to page 4.*

If you believe another situation exists, please contact the client's local SHIP office.

Height and Weight Chart Eligibility

To determine whether your client may purchase coverage, locate their height, then weight in the chart below. If their weight is in the Decline column, we are sorry; they are not eligible for coverage at this time.

Height	Decline Weight	Standard Weight	Decline Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10”	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +

Height	Decline Weight	Standard Weight	Decline Weight
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

Premium

Calculating Premium

Utilize Outline of Coverage

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if tobacco or non-tobacco use
- Find age/gender - Verify that the age and date of birth are the exact age as of the application date
- This will be your base monthly premium

Tobacco rates do not apply during Open Enrollment or Guaranteed Issue situations in the following states:

Iowa, Kentucky, Maryland, Michigan, New Jersey, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia

Types of Medicare Policy Ratings

- **Community rated** – The same monthly premium is charged to everyone who has the Medicare policy, regardless of age. Premiums are the same no matter how old the applicant is. Premiums may go up because of inflation and other factors, but not based on age.
- **Issue-age rated** – The premium is based on the age the applicant is when the Medicare policy is bought. Premiums are lower for applicants who buy at a younger age, and won't change as they get older. Premiums may go up because of inflation and other factors, but not because of applicant's age.
- **Attained-age rated** – The premium is based on the applicant's current age so the premium goes up as the applicant gets older. Premiums are low for younger buyers, but go up as they get older. In addition to change in age, premiums may also go up because of inflation and other factors.

Rate Type Available By State

State	Tobacco / Non-Tobacco Rates	Gender Rates	Attained, Issue or Community Rated	Tobacco Rates during Open Enrollment	Application Fee*
AL	Y	Y	A	Y	Y
AZ	Y	Y	I	Y	Y
DE	Y	Y	A	Y	Y
GA	Y	Y	I	Y	Y
IA	Y	Y	A	N	Y
IL	Y	Y	A	N	Y
IN	Y	Y	A	Y	Y
KS	Y	Y	A	Y	Y
KY	Y	Y	A	N	Y
MD	Y	Y	A	N	Y
MI	Y	Y	A	N	Y
MS	Y	Y	A	Y	Y
NC	Y	Y	A	N	Y
NE	Y	Y	A	Y	Y
NJ	Y	Y	A	N	Y
NM	Y	Y	A	Y	Y
OH	Y	Y	A	N	Y
PA	Y	Y	A	N	Y
SC	Y	Y	A	N	Y
TN	Y	Y	A	N	Y
TX	Y	Y	A	Y	Y
VA	Y	Y	A	N	Y
WV	Y	Y	A	Y	N

*Application Fee is $25.00 unless otherwise specified. In Mississippi the Application Fee is $6.00.

Household Discount (not applicable in all states)

If question 1 in the Household Discount Section on the application is answered "Yes," the individual is eligible for the discount. HHD is not available in all states; please refer to the state availability listing for details:

The household discount is available to:	State
HHD Rule 1: • Individuals who, for the past year, have resided with at least one, but no more than three, other adults who are age 50 or older; or • Individuals who live with another adult who is the legal spouse, including validly recognized civil union and domestic partners.	AL, AZ, DE, GA, IA, KS, MD, MI, MS, NC, NE, NM, SC, TN, TX, WV
HHD Rule 2: • Individuals who, for the last consecutive twelve (12) months, have resided continuously with at least one, but no more than three, other Medicare-eligible adults who own or are issued a Medicare supplement Policy underwritten by Shenandoah Life after January 1, 2014. Enter the existing Shenandoah Life policyholder's information in question 2.	OH
HHD Rule 3: • Individuals who reside together for at least one year and are applying at the same time together for – and are both issued – Medicare supplement/Select policies by Shenandoah Life. • Individuals who reside together for at least one year and where one of the individuals is already a Shenandoah Life Medicare supplement policyholder, holding a policy issued after January 1, 2014.	NJ
HHD Rule 4: • Individuals who, for the past year, have resided with at least one, but no more than three, other adults who are age 50 or older; or • Individuals who live with another adult who is the legal spouse, including validly recognized domestic partners.	VA
HHD Rule 5: • Individuals who, for the past year, have resided with at least one, but no more than three, other adults who are age 50 or older.	KY
HHD Rule 6: • Individuals who currently have a household resident (at least one, but not more than 3): o to whom you are either married or in a civil union partnership with; or o who own or are issued a Medicare supplement Policy underwritten by Shenandoah Life after January 1, 2014.	PA
Household Discount is not available in the following states:	IL, IN

The household discount is not available to individuals that have resided with 4 or more Medicare-eligible adults for the past year.

Application Fee

There will be a one-time application fee of $25.00* that will be collected with each applicant's initial payment. For a husband and wife written on the same application, $50 in fees must be collected. This will not affect the renewal premiums.

*Application fee may vary by state.

Completing the Premium on the Application

Premiums are calculated based upon the applicant's exact age at the time of application, not their age as of the requested coverage effective date; except if applying at age 64 ½ for effective date at age 65.

Initial and Renewal Premium (includes HHD, if applicable, and a one-time application fee)

- Determine how the client wants to be billed going forward (renewal) and
- Select the appropriate mode in the Plan/Premium Payment Information section on the application.
- Please calculate the premium based on the premium mode selected – e. g., if Quarterly mode is selected, please calculate the premium accordingly.
- Complete the calculation: Calculated Premium = Premium – HHD (if applicable) + App Fee = Total.
- PLEASE NOTE: *Monthly direct billing is not allowed.*

NOTE: **If utilizing Electronic Funds Transfer ("EFT") as a method of payment, please complete the Electronic Fund Transfer Authorization form in the New Business Pack. If paying the initial premium by EFT, the authorization form must be completed and submitted with the application. The policy will NOT be issued without this authorization.**

Collection of Premium

At least one month's premium must be submitted with the application. If a mode other than monthly is selected, then the full modal premium must be submitted with the application. Please remember that, if payment by ACH/EFT is selected, the initial premium will draft upon policy issuance.

NOTE: **Shenandoah Life Insurance Company does not accept post-dated checks, Money Orders, Cashier Checks, or payments from Third Parties, including any Foundations, as premium for Medicare supplement/Select policies. Immediate family and domestic partners are acceptable payors.**

Notices and Initial Premium Receipt

Complete this page as requested. Leave this page of the New Business Pack with the applicant.

Business Checks

Business checks are only acceptable if they are submitted for the business owner, or the owner's spouse.

Shortages

Shenandoah Life Insurance Company will communicate with the producer by telephone, e-mail or FAX in the event of a premium shortage in excess of $5.00 per modal premium. The application will be held in a pending status until the balance of the premium is received. Producers may communicate with Underwriting by calling 1-855-406-9085 or by FAX at 1-855-414-1098.

Refunds

Shenandoah Life Insurance Company will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

Our General Administrative Rule – 12 Month Rate

Our current administrative practice is not to adjust rates for 12 months from the effective date of coverage.

Application

NOTE: *Applications that have been modified or converted to fillable forms or other electronic formats will not be accepted unless prior approval was obtained by Shenandoah Life Insurance Company. Attempting to submit unapproved fillable forms or other electronic formats will not speed up the submission of an application. It is suggested to use our eApp.*

Properly completed applications should be finalized within 5-7 days of receipt at Shenandoah Life Insurance Company's administrative office. The ideal turnaround time provided to the producer is 11-14 days, including mail time.

Application Sections

The application must be completed in its entirety. The Medicare supplement application consists of seven sections that must be completed. Please review your applications for the information in the sections listed below before submitting. Any corrections need to be crossed through and initialed/dated by the applicant. White out on the application is not allowed. Additionally, any incomplete or missed questions may require that you obtain the applicant's initials/date and resubmit. Any corrections that are only initialed by the agent are not acceptable. If you need to submit additional information, or if you need to send in corrected pages, only submit the page(s) required, initialed/dated by the applicant, if needed. Please do NOT send the entire application, if you only need to send a few pages.

Plan Information Section

- Entire section must be completed.
- This section should indicate the Plan or policy form selected, effective date, premium paid, the premium payment mode selected (for both initial and renewal premium) and the policy delivery option. Please complete the premium calculation for the proper payment mode selected.

  Note: The effective date cannot be on the 29th, 30th, or 31st of the month.

Applicant Information Section

- Please complete the client's residence address in full. If correspondence is to be mailed to an address other than the applicant's residence address, please complete the mailing address in full.
- Age and Date of Birth are the exact age as of the application date.
- Medicare Card number, also referred to as the Medicare Beneficiary Identifier (MBI) or Health Insurance Claim ("HIC") number, is required for electronic claims payment.
- Height/Weight – This is required on underwritten cases.
- Answer the tobacco question. (Refer to the Calculating Premium section in this guide for a list of states where tobacco rates do not apply during Open Enrollment or Guaranteed Issue situations).

Section 4 – Miscellaneous Questions

- Verify the applicant answered "Yes" to receiving the Guide to Health Insurance and Outline of Coverage; it is required to leave these two documents with the client at the time the application is completed.
- Please indicate if the applicant is covered under Parts A and B of Medicare.

Section 5 – Insurance Policies

- If the applicant is applying during a Guaranteed Issue period, be sure to include proof of eligibility.
- If the applicant is replacing another Medicare supplement policy/certificate, complete question #2 and include the replacement notice.
- If the applicant is leaving a Medicare Advantage Plan, complete question #3 and include the replacement notice and copy of applicant's notice of disenrollment from Medicare Advantage program.
- If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union, employer Plan, or other non-Medicare supplement coverage, complete question #4.
- Verify if the applicant is covered through his/her state Medicaid program. If Medicaid is paying for benefits beyond the applicant's Part B premium or the Medicare supplement premium for this policy, then the applicant is not eligible for coverage.

Section 6 – Health Questions

- If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the health questions.
- If applicant is not considered to be in Open Enrollment or a Guaranteed Issue situation, all health questions must be answered.

  NOTE: In order to be considered eligible for coverage, all health questions must be answered "No".

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

Medication Information

- If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the medication information section.
- If applicant is not considered to be in Open Enrollment or a Guaranteed Issue situation, all medication information must be listed as indicated.

Section 7 – Signatures

- Signatures and dates: required by both applicant(s) and producer. The producer must be appointed in the state where the application is signed.
- If an application is taken on a Kansas resident, the producer must be appointed in Kansas and in the state where the application is signed.
- Regardless of state, writing agents must always have an effective license date prior to an application being signed. This is state law.

  NOTE: Applicant's signature must match name of applicant on the application. In rare cases where applicant cannot sign his/her name, a mark ("X") is acceptable if accompanied by a witness signature. For their own protection, the producer does not qualify as a witness.

- If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative. Please remember that Power of Attorney will only be accepted on Open Enrollment or Guaranteed Issue applications. A copy of the Power of Attorney document is required prior to issue – please refer to page 6 for more details on the POA Document.

Electronic Fund Transfer Authorization form and Method of Payment

- To establish monthly premium payments by EFT ("Electronic Funds Transfer"), complete entirely and submit. Please remember to remind the applicant that the first premium will be withdrawn from the account immediately when the policy is issued.
- **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 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.
- **For your protection, we strongly recommend making the draft date coincide with the policy effective date.**
- Please review the Grace Period definition with your applicants. The policy has a 31-day Grace Period following the paid to date, not the automatic bank draft date. If the premium is not paid within that Grace Period, the coverage will lapse. If coverage lapses, the policy is no longer in effect and claims incurred after the last paid to date will be denied. In order to be reinstated, medical underwriting may be required.

Health Questions

Unless an application is completed during Open Enrollment or a Guaranteed Issue period, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare supplement coverage if any of the health questions are answered "Yes". For a list of uninsurable conditions and the related medications associated with these conditions, please refer to the next sections in this guide.

There may, however, be situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition. Those conditions are listed in health questions 8, 9 and 10.

A condition is considered to be controlled if there have been no changes in treatment or medications for at least two years. If this situation exists and you would like consideration to be given to the application, answer the appropriate question "Yes," and attach an explanation stating how long the condition has existed and how it is being controlled. Be sure to include the names and dosages of all prescription medications.

If you have questions about the interpretation of health questions that refer to Cancer or Diabetes on the application, please see the information below.

Cancer Questions

Malignant Melanoma is considered an internal cancer. Applicants with this type of cancer are not eligible for coverage. Other types of skin cancer, such as basal cell, are not considered internal.

Diabetes Questions

People with diabetes mellitus that require, or have ever required, more than 50 units of insulin daily, or people with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complicating conditions listed on the application, are not eligible for coverage.

For purposes of this question, hypertension (high blood pressure) is considered a heart condition. Some additional questions to ask your client to determine if he/she does have a complication include:

1. Does he/she have eye/vision problems?
2. Does he/she have numbness or tingling in the toes or feet?
3. Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with well-controlled cases of hypertension and diabetes. A case is considered to be well controlled if the person is taking less than 50 units of insulin daily or no more than two oral medications for diabetes and no more than two medications for hypertension. A combination of less than 50 units of insulin a day and one oral medication would be the same as two oral medications if the diabetes were well controlled. In general, to verify stability, there should be no changes in the dosages or medications for at least two years. Individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower

Uninsurable Health Conditions

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

AIDS	Chronic Obstructive Pulmonary Disease (“COPD”)
Alzheimer’s Disease	Other chronic pulmonary disorders to include:
Other cognitive disorders to include:	Asbestosis
Cerebrovascular Disease with cognitive deficits	Bronchiectasis
Dissociative Amnesia	Chronic bronchitis
Huntington’s Chorea (Huntington’s Disease)	Chronic Obstructive Lung Disease (“COLD”)
Mild Cognitive Impairment (“MCI”)	Chronic Asthma
Delirium	Chronic Cardiopulmonary Disease
Organic Brain Disorder	Chronic Interstitial Lung Disease
Post-Concussion Syndrome with residual problems	Chronic Pulmonary Fibrosis
Senile Dementia	Cystic Fibrosis
Amyotrophic Lateral Sclerosis (Lou Gehrig’s Disease)	Pulmonary Hypertension
ARC	Sarcoidosis
Any cardio-pulmonary disorder requiring oxygen	Chronic Kidney/Renal Disease
Cirrhosis	Chronic Nephritis
Chronic Hepatitis	Chronic Glomerulonephritis
Chronic Hepatitis B	Chronic Protein loss in the Urine (proteinuria)
Chronic Hepatitis C	Requiring 4 or more MD office visits per year in the follow up of renal disease
Chronic Hepatitis D	Chronic Renal Insufficiency
Autoimmune Hepatitis	Hypertensive Chronic Renal Disease
Chronic Active Hepatitis	Nephropathy
Chronic Steatohepatitis	Nephrotic Syndrome
Diabetes* - Insulin >50 units/day	Stage 3, Stage 4 or Stage 5 Chronic Kidney Disease
Emphysema	End-stage Renal Disease (“ESRD”)
Lupus - Systemic	Kidney disease requiring dialysis
Multiple Sclerosis	Kidney (renal) Failure/End-Stage Renal Disease (ESRD)
Myasthenia Gravis	Any kidney disorder that has the applicant being evaluated for, or who is currently on dialysis
Organ transplant	Parkinson’s disease
Osteoporosis with fracture	Scleroderma

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

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, further diagnostic evaluation, treatment or therapy
- If applicant's height/weight is in the decline column on the chart

Partial List of Medications Associated with Uninsurable Health Conditions

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

Medication	Condition	Medication	Condition
3TC	AIDS	DuoNeb	COPD
Acetate	Prostate Cancer	Ebixa	Alzheimer's Disease
AccuNeb	COPD	Eldepryl	Parkinson's Disease
Alkeran	Cancer	Eligard	Prostate Cancer
Amantadine	Parkinson's Disease	Embrel	Rheumatoid Arthritis
Anoro Ellipta	COPD	Emtriva	HIV
Apokyn	Parkinson's Disease	Epivir	HIV
Aptivus	HIV	Epogen	Kidney Failure, AIDS
Aricept	Dementia	Ergoloid	Dementia
Artane	Parkinson's Disease	Esbriet	Chronic Pulmonary Disorder
Atripla	HIV	Exelon	Dementia
Aubagio	Multiple Sclerosis	Extavia	Multiple Sclerosis
Avonex	Multiple Sclerosis	Fuzeon	HIV
Azilect	Parkinson's Disease	Galantamine	Dementia
AZT	AIDS	Geodon	Schizophrenia
Baclofen	Multiple Sclerosis	Gilenya	Multiple Sclerosis
BCG	Bladder Cancer	Glatopa	Multiple Sclerosis
Betaseron	Multiple Sclerosis	Gold	Rheumatoid Arthritis
Bicalutamide	Prostate Cancer	Haldol	Psychosis
Breo	COPD	Herceptin	Cancer
Brovana	COPD	Hydergine (LC)	Dementia
Carbidopa	Parkinson's Disease	Hydrea	Cancer
Casodex	Prostate Cancer	Hydroxyurea	Melanoma, Leukemia, Cancer
Cerefolin	Dementia	Imuran	Immunosuppression, Severe Arthritis
Cogentin	Parkinson's Disease	Incruse Ellipta	COPD
Cognex	Dementia	Indinavir	AIDS
Combivir	HIV	Insulin (>50 units/day)	Diabetes
Comtan	Parkinson's Disease	Interferon	AIDS, Cancer, Hepatitis
Copaxone	Multiple Sclerosis	Invega	Schizophrenia
Crixivan	HIV	Invirase	AIDS
Cytoxan	Cancer, Severe Arthritis, Immunosuppression	Kaletra	HIV
D4T	AIDS	Kemadrin	Parkinson's Disease
DDC	AIDS	Lasix / Furosemide (>60 mg/day)	Heart Disease
DDI	AIDS	L-Dopa	Parkinson's Disease
DES	Cancer	Lemtrada	Multiple Sclerosis
Daliresp	COPD	Letairis	Pulmonary Hypertension
Donepezil	Alzheimer's Disease	Leukeran	Cancer, Severe Arthritis, Immunosuppression

Medication	Condition	Medication	Condition
Leuprolide	Prostate Cancer	Reyataz	HIV
Leuprolide Acetate	Prostate Cancer	Rilutek	ALS
Lomustine	Cancer	Riluzole	ALS
Levodopa	Parkinson's Disease	Risperdal	Psychosis
Lexiva	HIV	Ritonavir	AIDS
Lioresal	Multiple Sclerosis	Rivastigmine Tartrate	Alzheimer's Disease
Lomustine	Cancer	Symmetrel	Symmetrel
Lupron	Cancer	Selzentry	HIV
Lupron Depot (Ped)	Prostate Cancer	Sinemet	Parkinson's Disease
Megace	Cancer	Stalevo	Parkinson's Disease
Megestrol	Cancer	Stelazine	Psychosis
Mellaril	Psychosis	Stiolto Respimat	COPD
Melphalan	Cancer	Sustiva	AIDS
Methotrexate (> 25 mg/wk.)	Rheumatoid Arthritis	Sandimmune	Immunosuppression, Severe Arthritis
Memantine	Alzheimer's Disease	Tacrine	Dementia
Metrifonate	Dementia	Tasmar	Parkinson's Disease
Mirapex	Parkinson's Disease	Teslac	Cancer
Myleran	Cancer	Tecfidera	Multiple Sclerosis
Namenda	Alzheimer's Disease	Thiotepa	Cancer
Natrecor	CHF	Thorazine	Psychosis
Navane	Psychosis	Tudorza	COPD
Nelfinavir	AIDS	Trelstar-LA	Prostate Cancer
Neoral	Immunosuppression, Severe Arthritis	Trelegy Ellipta	COPD
Neupro	Parkinson's Disease	Triptorelin	Prostate Cancer
Norvir	HIV	Trizivir	HIV
Novantrone	Multiple Sclerosis	Truvada	HIV
Nucala	Chronic Pulmonary Disorder	Tysabri	Multiple Sclerosis
OFEV	Chronic Pulmonary Disorder	Valcyte	CMV HIV
Paraplatin	Cancer	VePesid	Cancer
Parlodel	Parkinson's Disease	Viadur	Prostate Cancer
Permax	Parkinson's Disease	Videx	HIV
Plegridy	Multiple Sclerosis	Vincristine	Cancer
Prezista	HIV	Viracept	HIV
Procrit	Kidney Failure, AIDS	Viramune	AIDS
Prolixin	Psychosis	Viread	HIV
Provenge	Prostate Cancer	Zanosar	Cancer
Razadyne (ER)	Dementia	Zelapar	Parkinson's Disease
Rebif	Multiple Sclerosis	Zerit	HIV
Remicade	Rheumatoid Arthritis	Ziagen	HIV
Reminyl	Dementia	Zinbryta	Multiple Sclerosis
Remodulin	Pulmonary Hypertension	Ziprasidone	Schizophrenia
Requip	Parkinson's Disease	Zoladex	Cancer
Rescriptor	HIV	Zometa	Hypercalcemia in cancer
Retrovir	AIDS		

Mailing Applications to Prospects

Mailing a completed application adds a few steps to the normal sales process. Below is a description of the necessary steps.

The Facts

Standard Operating Procedures

Face-to-face completion of the application and interview is always preferred and expected as standard practice. Telesales via a call center operation are not allowed.

When Face-to-Face Interviews Aren't Possible

There will be times when you cannot meet with prospects in person. When necessary and with the prospect's consent, you may conduct the interview over the phone and mail the completed application to the prospect.*

* Applies only to Shenandoah Life Insurance Company Medicare supplement products and does not change the current underwriting requirements for other Shenandoah Life Insurance Company products.

This application process should not be the norm. This option is to be used only with people who have responded to lead-generation material or with whom you have ongoing client relationships. It is not appropriate for cold calling as national and corporate do-not-call rules and other compliance requirements apply. When calling a prospect who responds to a lead, always attempt to schedule a face-to-face interview. However, if the prospect refuses to schedule a face-to-face interview, you may continue the sales process on the phone. You need to begin by explaining to the prospect the following steps you will take to complete the sale.

You will:

- Ask the prospect the questions on the application and required forms; mail the completed application and required forms to the prospect for their review and signature;
- Tell the prospect that they need to carefully review the application and forms for completeness and accuracy and then sign;
- Have the prospect return the signed application, forms and premium payment to you in a postage paid envelope;
- Upon return of the application and other forms, verify that all the required forms are completed and signed;
- Submit the application through the usual channel; and
- When issued, deliver the policy according to current policy delivery guidelines.

The Sales Process

The method for selling Medicare supplements doesn't change: Call a lead, review coverage, ask for the sale, complete and sign the application, submit the business, deliver the policy. The difference is that parts of the sales process as noted here may be conducted via the telephone instead of face-to-face. Consequently, there are a few more steps, outlined on the next two pages, to complete the sale.

Improve Time Service

Submitting complete and accurate information ensures quick timely service. Other factors are:

- You must be appointed in the state where the application is signed.
- If an application is taken on a Kansas resident, the producer must be appointed in Kansas and in the state where the application is signed.
- You cannot sign a blank application.
- It is not acceptable to mail blank applications, brochures and outlines as prospecting material.
- The applicant's state of residence controls the application, forms and premium.
- The client must return the signed applications, forms and premium payment to you and should not submit them directly to Shenandoah Life Insurance Company.
- Incomplete application submissions will be returned to you, so review thoroughly.
- If you solicited the business, you must be the one to sign the corresponding application.

Spot Check for Customer Satisfaction

To ensure that customers who complete Medicare supplement applications over the phone perceive this process as positive and that it's followed correctly, Shenandoah Life Insurance Company will call a portion of these applicants to:

- Verify the content and accuracy of the information submitted
- Determine their overall satisfaction level
- Confirm that producers followed this process

The Process

Please complete the following steps when you conduct the Medicare supplement sales interview over the phone and mail the completed application to the prospect:

Step 1 – Call the prospect that responded to a lead.

When you receive a lead, telephone the person to discuss the benefits, rates and answer questions. Attempt to schedule a face-to- face appointment to review details, ask for the sale and apply for coverage.

If the prospect prefers to continue the sales process on the phone, continue to Step 2.

Note: You must be appointed in the state the application will be signed.

Step 2 – Communicate the process.

If the prospect wants coverage and prefers to apply for a policy over the phone instead of in person, explain the process before proceeding to Step 3:

- Producer asks the prospect the questions on the application and required forms.
- Producer mails the completed application and forms to the prospect for review and his/her signature.
- Prospect carefully reviews the application and forms for completeness and accuracy and signs them.
- Prospect returns the application, forms and premium in the provided postage-paid envelope.
- Producer verifies all the required forms are completed and signed.
- Producer submits the application and required forms through the usual channel.
- When issued, the producer delivers the policy according to current policy delivery guidelines.

Step 3 – Complete the required forms over the telephone.

Ask the prospect all the questions on the application, replacement notice and state-special forms (if needed) and print the answers. Repeat his/her responses for accuracy.

Note: Privacy requirements prohibit discussing eligibility for other products over the telephone.

Step 4 – Mail forms to the Prospect

Place the following in an envelope and mail to the prospect:

- Cover letter (attach your business card):
- Indicating which forms to sign and what to return to you
- Asking the prospect to verify all information including his/her Medicare card number, to make necessary corrections and initial changes
- Inviting the prospect to contact you with any questions
- Application and forms (replacement notice and state special forms, if needed) with signature areas and premium highlighted
- Outline of Coverage, Guide to Health Insurance for People with Medicare
- Postage-paid addressed envelope

Note: Plan availability and premium rates are based on when the application is signed. The producer must communicate changes in Plan availability or premium to the prospect before submitting the forms to Shenandoah Life Insurance Company.

Step 5 – Prospect Reviews and Signs Forms

Once the prospect receives the application and forms, he/she:

- Verifies the responses and initials any corrections
- Signs the application and forms as highlighted
- Returns the application and forms to the producer in the provided envelope

Step 6 – Verify and Sign Forms

When you receive the envelope from the prospect, you:

- Check that you have the first premium payment and the completed and signed application and forms
- Verify that the prospect initialed any changes
- Sign the required items
- Send the Premium Receipt to the applicant

Note: The producer who solicited the business must sign the application.

Step 7 – Submit for Processing

Submit the business (application and forms) in the usual manner as noted in the New Business Pack.

Step 8 – Deliver the policy according to current policy delivery guidelines

Questions? Call us at 1-855-406-9085

Required Forms

Application

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

The agent is responsible for submitting completed applications to Shenandoah Life Insurance Company administrative office.

Producer Certification

This form must be signed by the agent and the applicant(s) and returned with the application.

Authorization to Release Confidential Medical Information or HIPAA Authorization Form

The HIPAA form must have a current and clearly written date. It is required with all underwritten applications.

Notices and Initial Receipt, and Notice of Information Practices

Receipt must be completed and provided to applicant as receipt for premium collected. Notice must be provided to applicant.

Replacement Form(s)

The replacement form(s) must be signed and submitted with the application when replacing any Medicare supplement or Medicare Advantage application. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application.

Select Disclosure Agreement

The Select Disclosure Agreement form must be signed and submitted with the application when a Select Plan is chosen (Select Plan not available in all states).

Agent or Witness Certification for Non-English Speaking and/or Reading Applicants

If the applicant does not speak English, this form is to be completed by the agent if agent is translating or a witness if a witness is translating. A copy must be submitted with the application and a copy left with the Applicant.

State Special Forms

Forms specifically mandated by states to accompany point-of-sale material.

Illinois

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

Iowa

Important Notice before You Buy Health Insurance – To be left with the applicant.

Kentucky

Medicare Supplement Comparison Statement – This form should be completed when replacing a Medicare Supplement or Medicare Advantage plan and submitted with the application.

Maryland

Eligible Persons for Guaranteed Issue and Open Enrollment – To be left with the Applicant.

Nebraska

Senior Health Counseling Notice – This form is to be left with the Applicant.

New Mexico

New Mexico Confidential Abuse Information – Optional form, submit copy if completed.

Ohio

Administrative Information – This form is to be submitted with the application.

Solicitation and Sale Disclosure – This form is to be left with the Applicant.

Pennsylvania

Guaranteed Issue and Open Enrollment Notice – To be left with applicant.

South Carolina

Duplication of Insurance – This form should be completed and submitted with the application when duplicating Medicare supplement insurance with other health insurance.

Texas

Definition of Eligible Person for Guaranteed Issue Notice – This notice is provided as the last page of the application.

Shenandoah Life Insurance Company

Administrative Office
PO Box 14558
Clearwater, FL 33766-4558

Phone: 1-**855-406-9085**

www.shenlife.com