F. ELIGIBILITY QUESTIONS

To the best of your knowledge and belief:	Applicant: A	B
1. Are you applying during an open enrollment period?	☐ Y ☐ N	☐ Y ☐ N
A. Did you turn age 65 in the last six months?	☐ Y ☐ N	☐ Y ☐ N
B. Did you enroll in Medicare Part B in the last six months?	☐ Y ☐ N	☐ Y ☐ N

If you answered "YES" to either question, what is your Medicare Part B effective date?

Applicant A _____/_____/_____ **Applicant B** _____/_____/_____

2. Are you applying during a guaranteed issue period? (NOTE: Refer to the Guide to Health Insurance for People with Medicare to help determine if you are eligible. If you answered "YES", please attach proof of eligibility.)	☐ Y ☐ N	☐ Y ☐ N

If you are applying during an open enrollment or guaranteed issue period, SKIP Section G through Section I AND GO TO Section J.

G. MEDICAL QUESTIONS (PART A)

For all plans, please answer ALL questions.
NOTE: An interviewer may call to confirm and verify the information you provide on this application.
(If "YES" is the answer to questions 1-7, that person is not eligible for coverage.)

To the best of your knowledge and belief:	Applicant: A	B
1. Are you currently confined to a wheelchair or any motorized mobility device?	☐ Y ☐ N	☐ Y ☐ N
2. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?	☐ Y ☐ N	☐ Y ☐ N
3. Have you been medically diagnosed with, treated for, or had surgery for any of the following:		
A. Chronic kidney disease (Stages 3, 4 or 5), kidney failure, or kidney disease requiring dialysis?	☐ Y ☐ N	☐ Y ☐ N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?	☐ Y ☐ N	☐ Y ☐ N
C. Alzheimer's disease, dementia or any other cognitive disorder?	☐ Y ☐ N	☐ Y ☐ N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?	☐ Y ☐ N	☐ Y ☐ N
E. Systemic lupus, scleroderma or myasthenia gravis?	☐ Y ☐ N	☐ Y ☐ N
F. Chronic hepatitis or cirrhosis?	☐ Y ☐ N	☐ Y ☐ N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)?	☐ Y ☐ N	☐ Y ☐ N
4. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)?	☐ Y ☐ N	☐ Y ☐ N
5. Do you have Osteoporosis, and as a result, experienced a fracture?	☐ Y ☐ N	☐ Y ☐ N
6. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?	☐ Y ☐ N	☐ Y ☐ N
7. Do you have an implanted cardiac defibrillator?	☐ Y ☐ N	☐ Y ☐ N

H. MEDICAL QUESTIONS (PART B)

(If "YES" is answered to any of the following questions 8-12 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the best of your knowledge and belief:	Applicant: A	B
8. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?	☐ Y ☐ N	☐ Y ☐ N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?	☐ Y ☐ N	☐ Y ☐ N

H. MEDICAL QUESTIONS (PART B) - CONTINUED

To the best of your knowledge and belief:	Applicant: A	B
8. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
C. Alcoholism or drug abuse?	☐ Y ☐ N	☐ Y ☐ N
D. Any mental or nervous disorder requiring treatment (including hospital confinement)?	☐ Y ☐ N	☐ Y ☐ N
E. Internal cancer, lymphoma or melanoma?	☐ Y ☐ N	☐ Y ☐ N
F. A stroke or transient ischemic attack (TIA)?	☐ Y ☐ N	☐ Y ☐ N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement?	☐ Y ☐ N	☐ Y ☐ N
9. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)?	☐ Y ☐ N	☐ Y ☐ N
B. Had any changes in your medications within the past two years?	☐ Y ☐ N	☐ Y ☐ N
10. Have you been hospital confined three or more times in the past two years for a same or similar condition?	☐ Y ☐ N	☐ Y ☐ N
11. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed?	☐ Y ☐ N	☐ Y ☐ N
12. Have you used any form of tobacco, an electronic cigarette (e-cig) or other nicotine product in the past 12 months?	☐ Y ☐ N	☐ Y ☐ N

Applicant A *Height Feet and inches* Weight *Pounds*

Applicant B *Height Feet and inches* Weight *Pounds*

NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.

I. MEDICATION INFORMATION

(**If you are applying for ANY plan OUTSIDE of an open enrollment or guaranteed issue period, please answer the following question.**

If "YES", list all over-the-counter or prescription medications you are currently taking or have been prescribed in the last 2 years

To the best of your knowledge and belief:	Applicant: A	B
1. Are you currently taking, or have you been prescribed during the previous 2 years, any prescription drugs or over-the-counter medications?	☐ Y ☐ N	☐ Y ☐ N

APPLICANT A

Medication Name (copy of pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?		Prescribed by Primary Physician?		Diagnosis/Condition
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	

APPLICANT B

Medication Name (copy of pharmacy label)	Dosage	Frequency	Have you taken this medication for more than 2 years?		Prescribed by Primary Physician?		Diagnosis/Condition
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	
			☐ Y	☐ N	☐ Y	☐ N	