APPLICANT MEDICARE NUMBER

3 Guaranteed Acceptance

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ◯ Yes ◯ No

   If you are age 50 to 64, 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 that date or within six months in which you are notified of a retroactive determination of Medicare eligiblity.

   If you are age 50 to 64, you are eligible for Guaranteed Acceptance in Plan D if your Medicare Part B effective date is prior to 1/1/2020, you apply within six months of that date and you are not covered by another Medicare Supplement Plan; or if your Medicare Part B effective date is after 1/1/2020 and you apply within 12 months of that date.

2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed acceptance? ◯ Yes ◯ No
   Additionally, if you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.

   If you answered yes to either question in this section, you qualify for the Preferred rates.
   Please go directly to Section 6.

4 Medical Questions

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS. A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

HEIGHT ☐ **FT** ☐☐ **IN** **WEIGHT** ☐☐☐ **LBS**

1. In the last year, have you been hospitalized, confined to a nursing facility, or are you bedridden or confined to a wheelchair? ◯ Yes ◯ No
2. In the past 90 days have you received Home Health care? ◯ Yes ◯ No
3. Have you used supplementary oxygen in the last year? ◯ Yes ◯ No
4. Do you now have or within the last two years have you taken medication or been advised to take medication for or received medical advice, treatment or been advised that you need treatment or surgery for:
   a. Heart, Coronary, or Carotid Artery Disease, high blood pressure (hypertension) or high cholesterol, Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders? ◯ Yes ◯ No
   b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders? ◯ Yes ◯ No
   c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Systemic Lupus, Hepatitis (excluding A or E), Lou Gehrig's Disease? ◯ Yes ◯ No
   d. Inflammatory Bowel Disease, Crohn's Disease, Ulcerative Colitis, or Barrett's Esophagus? ◯ Yes ◯ No
   e. Alzheimer's Disease, senile dementia, brain seizures, epilepsy, senility disorder, schizophrenia, major depressive disorders, other mental or nervous disorders, liver disease or disorder, cirrhosis, alcoholism or drug abuse? ◯ Yes ◯ No
   f. Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) infection or blood disorder? ◯ Yes ◯ No
   g. Kidney disease requiring dialysis or Kidney failure? ◯ Yes ◯ No
   h. Diabetes? ◯ Yes ◯ No
   i. Internal cancer, leukemia or melanoma? ◯ Yes ◯ No

APPLICANT MEDICARE NUMBER

j. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? ◯ Yes ◯ No

k. Rheumatoid arthritis, Paget's Disease, Osteoporosis, degenerative bone or joint disorder, degenerative disk disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries, or chronic pain? ◯ Yes ◯ No

l. Organ, bone marrow or stem cell transplant or awaiting transplant (excluding corneas)? ◯ Yes ◯ No

5. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

_____

_____

_____

5 Premium Determination

All applicants must answer these questions, unless applying during a Medicare Supplement Open Enrollment Period or qualify for guaranteed acceptance as indicated in Section 3.

1. Did you have Medicare coverage prior to age 65? ◯ Yes ◯ No
2. Have you used tobacco products within the last 12 months? ◯ Yes ◯ No

If your application is accepted, and you answered **No** to both questions, you qualify for the Preferred rates. To determine your premium, refer to your Outline of Coverage.

6 Discount Determination

If you qualify for the Household Discount disclosed in your Outline of Coverage, please provide the name and Medicare number of the individual living at your current address.

LAST NAME **FIRST NAME** **MI**

MEDICARE NUMBER

7 Payment Options

PREMIUM QUOTE

. **Premium quoted based on all applicable discounts.**

INITIAL PAYMENT

. **Amount you are submitting with your application. You must submit at least your first month's premium with all applicable discounts.**

CHECK NUMBER **Please indicate ACH in the Check Number fields if this is the preferred method for initial premium payment.**

MONEY ORDER

➤ **You Must Read and Sign**