Bankers Fidelity®

Bankers Fidelity Life Insurance Company®

Field Agent's Underwriting Guide

Underwriting companies:

Bankers Fidelity Life Insurance Company®

Bankers Fidelity Assurance Company®

Atlantic Capital Life Assurance Company® d/b/a Bankers Fidelity

UNDERWRITING PHILOSOPHY

Our underwriting team is solutions-focused and works hand-in-hand with you to support your efforts and help you reach your goals.

We prioritize responsive, high-quality service and strong collaboration—both across our organization and with our sales partners—to ensure thoughtful, effective risk management.

Together, we're building a company you can rely on, one that delivers long-term value and supports your continued growth. Every day, we strive to earn your trust and contribute to your success.

CONTACT INFORMATION

New Business Mailing Information:

Send via USPS, Overnight, or Certified to:

Bankers Fidelity
Attention: New Business
4370 Peachtree Road NE
Atlanta, GA 30319

Telephone Numbers:

Agent Support	866-458-7503
Marketing	866-458-7505
Underwriting/New Business	866-458-7501
Policyholder Services	866-458-7500 404-926-4033 Fax
Claims	866-458-7499
Hours of Operation:	8:00 a.m. – 5:30 p.m. EST Monday – Thursday 8:00 a.m. – 5:00 p.m. EST Friday

Email Addresses:

Agent Support	agentsupport@bflic.com
Policyholder Services	bflphs@bflic.com
Agency	bflagency2@bflic.com
New Business Applications	bfluw@bflic.com
Questions for Underwriting Only	underwriting@bflic.com
Claims	claimsservices@bflic.com

New Business Fax Numbers:

Main	404-926-4030
Alternative	877-739-1804

Proposed Insured:

The **Proposed Insured** is the person whose life and health are evaluated to determine eligibility for a life insurance policy.

Sometimes, someone other than the Proposed Insured, called the **Applicant**, submits the application for the policy. Additionally, a life insurance policy has an **Owner**, who may be a different person from the Proposed Insured or Applicant.

This document primarily refers to the Proposed Insured. However, when legal correspondence must be sent to the Owner or Applicant, those terms are implied as appropriate.

SUBMISSION PROCESS

SITUATION	SUBMIT APPLICATION NO EARLIER THAN...
Fully Underwritten / Guarantee Issue	3 months before the requested effective date
Open Enrollment	6 months before the requested effective date

The Application

There are several important points you should remember when completing an application.

Residence Address:

- A physical residence address is required.
- PO Boxes may only be used as the mailing address.

Complete All Fields:

Answer every question on the application.

- Fill in all blanks.
- Obtain all required signatures and dates on every form.

HIPAA Authorization:

A completed and signed HIPAA Authorization form must be submitted with every application, except in the following cases:

- Open Enrollment
- Guarantee Issue
- Birthday Rule
- Internal Replacements on the same company

Use Current Forms:

Always use the most up-to-date forms approved for the state where the application is signed. This includes:

- Applications
- Replacement Notices
- Authorizations

All forms are available in the ADDS Library for download and printing.

Medical Section

Ask Questions Exactly as Written:

- Read each medical question verbatim from the application.
- Pay close attention to any time frames specified.

Clarification of Medical Terms:

For all medical/health questions, ask if the Proposed Insured has:

- **Had:** Currently has or previously had the condition within the specified time frame.
- **Treated for:** Received treatment (including medication or ongoing care) for the condition within the time frame, regardless of when it was first diagnosed.
- **Diagnosed with:** Was diagnosed by a medical professional within the time frame.

Prescription Drug List:

- List all currently prescribed medications, even if not taken as directed.
- Use the label on the bottle to obtain accurate information.
- If no medications are prescribed, write "None".
- Do not use "N/A" or "Not Applicable".

Commonly Missed Information

When completing and submitting applications, double-check the following frequently overlooked items:

- Doctor/Physician Information: Include the full name, address, and telephone number.
- Medicare Beneficiary Identifier (MBI): Must be provided and legible.
- Replacement Form: Submit a completed form if the application involves replacing an existing policy.
- Proposed insureds telephone number and email address.

Submission Guidelines

To ensure timely and accurate processing, follow these submission rules:

Timeliness

Application Receipt Window:

- Applications must be received within 30 days of the signature date.
- Once received, they remain valid for 30 days from the date signed.

Policy Effective Date:

- Must be within 90 days of the application date.
  - Exception: For 6-month open enrollment cases, the effective date can be up to 6 months after the application date.
- Backdating is not allowed.
- Must be on or after the application date and allow sufficient time for underwriting to be completed.

Application Changes

Initialing Changes:

- Any changes made to the application must be initialed by the applicant.
- Uninitiated changes will require a signed amendment.

Effective & Draft Dates

Restricted Dates:

- The 29th, 30th, and 31st of any month are not allowed as policy effective or draft dates.
- If selected, the date will be moved to the 1st of the following month.

Rate Determination

How Rates Are Set:

- Applications must be written and signed in the applicant's resident state.
- Based on the state where the application is physically signed.
- Medicare Supplement rates are based on the resident state of the applicant.
- The agent must be licensed and appointed in that state.

  Note: If the mailing address and residence address zip codes differ, rates are based on the mailing address area

Application Corrections

If an error is found on a recently submitted application, most issues can be resolved by contacting Underwriting directly through email, fax, or phone.

However, there are specific situations where a new application must be submitted:

- The wrong application form or version was used
- The applicant's first, last, or full legal name is incorrect
- The application was originally submitted as Open Enrollment or Guarantee Issue, but Underwriting requires a fully underwritten application instead
- The initial premium was returned and more than 30 days have passed since the requested effective date
- The application was withdrawn because pending requirements were not met, and more than 30 days have passed since the initial request for those items*

  *Excluding Open Enrollment, 63-day Guarantee Issue, and Birthday Rule

Tobacco Status

To qualify for non-tobacco rates, the Proposed Insured must meet the following criteria:

- No use of tobacco or nicotine products in any form within the time frame specified on the application.

Products That Disqualify for Non-Tobacco Rates

The following are considered tobacco use, even if used occasionally:

- E-cigarettes / Vaporizers
- Cigars
- Pipes
- Nicotine gum/patches
- Smoking cessation medications

Daily marijuana use results in a decline.

Initial Premium Payment Instructions

In the "Initial Premium Payment" section of the application, follow these steps carefully:

Selection & Draft Date

- Choose a payment method for the initial premium (e.g., check, draft, or credit card).
- Specify the draft date for the initial premium.
- If no date is provided, the draft will occur on the policy's effective date.

Note: The draft date for future recurring payments can differ from the initial draft date.

Timing of Draft

The initial premium will not be drafted until the application has been approved.

Accepted Payment Methods

- Check
- Credit Card (Only accepted on e-app)

Unacceptable Payment Methods

C.O.D. (Cash on Delivery) and money orders are not accepted.

Check Payments

- Make checks payable to Bankers Fidelity.
- Include a voided check if setting up bank drafts.
- Post-dated checks are not allowed.

Credit Card Payments

Accepted cards:

- American Express, Mastercard, VISA, and Discover

*A 3% fee applies to monthly credit card payments on most products.

Important Notes

Credit card payments are exclusively accepted through the electronic application and are not available for paper applications. An email address is required to complete the e-app process.

Recurring Premium Payment Guidelines

Payment Due Date

- The recurring premium can be scheduled for any day of the month, except the 29th, 30th, or 31st.
- A 30-day grace period is provided for each payment, during which the policy remains active without lapsing.

Unaccpetable Payment Methods

- Cash
- Agent's personal check or credit card
- Money Order

Effective Date of Insurance

Please note that insurance coverage does not begin until all of the following conditions are met:

- All underwriting requirements are satisfied.
- The policy has been issued.
- The policy is received by the owner.
- The first premium is paid and honored upon first presentation.

All of the above must occur:

- During the Proposed Insured's lifetime, and
- Before any change in the Proposed Insured's health as stated on the application.

Until these conditions are fulfilled, no coverage is in effect.

Household Discount

A Household Premium Discount is available to eligible applicants for the following products:

- Medicare Supplement
- Vantage Recovery

Discount Details

The discount percentage varies by product.

Refer to the rate sheets for each product to view the applicable discount amount

Medicare Supplement – Household Discount Eligibility

Qualified Applicants

To be eligible for the Household Discount, applicants must meet one of the following criteria:

- Be married and residing with their spouse, OR
- Have been residing with 1 to 3 other individuals, all aged 50 or older, for at least the last 12 consecutive months.

State-Specific Note:

In Montana (MT), New Jersey (NJ), and Ohio (OH), at least one other person in the household must have or be approved for a Medicare Supplement policy issued by us.

Application Requirement

The "Household Discount Information" section of the application must be completed by the Proposed Insured to be considered for the discount.

Discontinuation of Household Discount

The discount will be discontinued if the Insured:

- Is no longer residing with their spouse,
- Is no longer residing with at least one person aged 50 or older,
- Is residing with more than three other individuals, regardless of age.

State Exceptions:

- Kentucky (KY) and Tennessee (TN): Once qualified, the Household Discount does not terminate.
- Ohio (OH): The discount terminates upon the death of the companion policyholder.

Special Qualification Scenarios

- A Medicare Supplement policy issued to someone under age 65 and disabled may be used to qualify an applicant age 65 or older for the discount.
- A policy issued before June 1, 2010 may also be used to qualify a current applicant age 65 or older. However, the older policy itself is not eligible for the discount.

UNDERWRITING PROCESS

Telephone Interviews

Contact information:

Phone: 866-235-7580

Hours of Operation:

Monday - Friday: ..... 8:00 a.m.–9:00 p.m. CST

Saturday: ..... 9:00 a.m.–3:00 p.m. CST

Sunday: ..... Closed

Telephone Interview Process

Medicare Supplement/ Vantage Care/ Vantage Flex *Plus*/ Vantage Recovery/ Vantage Secure

Interview Overview

- **Purpose:** To obtain additional underwriting information when necessary.
- **Duration:** Approximately 10 minutes for a full interview.
- **Recording:** The conversation is recorded and used as part of the risk analysis.
- **Selection:** Applications are selected randomly for interviews.
- **Initiated by:** Only the Home Office can order the interview.

Interview Exclusions

Telephone interviews are not required for:

- Open Enrollment
- Guarantee Issue
- Birthday Rule

*Conversions between: Bankers Fidelity Life Insurance Company, Bankers Fidelity Assurance Company, Atlantic Capital Life Assurance Company (if the existing policy has been in force for at least 1 year)

Additional Underwriting Requirements

Prescription Drug Search (Rx)

Conducted as part of the underwriting review.

Used to:

- Assess risk and eligibility
- Validate any errors, omissions, or misrepresentations on the application

Medical Claims Data

This information is derived from billing records submitted by hospitals and healthcare providers for services rendered.

Provides insight into:

- Conditions treated
- Services rendered
- Often reveals information not found in prescription records.

Doctor/Physician Statement

May be requested for clarification of medical history.

Must include:

- Doctor's office letterhead
- Prescribing/treating physician's name
- Specific condition for which the medication was prescribed
- A statement confirming the patient is not diagnosed with a declinable condition

Medications

Disqualifying Medications

- Medications listed in the "Disqualifying Medications" section of each product's underwriting guidelines will disqualify the Proposed Insured from coverage.
- If the applicant is taking any of these medications, the application should not be submitted.

Preferred Underwriting Disqualifiers

- Medications listed under "Preferred Underwriting Disqualifying Medications" may disqualify the applicant from receiving a Preferred Underwriting classification, even if they do not disqualify them from coverage entirely.

Medication Combinations

- A combination of medications, even if each is not disqualifying on its own, may result in:
  - Disqualification from coverage, or
  - Ineligibility for Preferred Underwriting
- All active ingredients in combo meds will be counted separately

Special Circumstances

- If a disqualifying medication is being used for a non-disqualifying condition, clearly note the condition on the application.
- A Doctor/Physician's statement may be required to:
  - Confirm the reason for the prescription
  - Rule out a disqualifying diagnosis

Important Notes

- The Disqualifying Medications list includes the most common disqualifying drugs for each product.
- It is not all-inclusive—other medications not listed may still result in disqualification.

Replacements

A replacement occurs when an applicant intends to terminate or alter an existing in-force insurance policy while applying for a new policy with Bankers Fidelity.

Types of Replacements

- Internal Replacement
  - Replacing an existing policy with a new policy from the same or an affiliated company
- External Replacement
  - Replacing a policy from another (outside) company with a new policy from:
    - Bankers Fidelity Life Insurance Company® (BFLIC)
    - Bankers Fidelity Assurance Company® (BFAC)
    - Atlantic Capital Life Assurance Company® (ACLAC)

What Qualifies as a Replacement?

Altering an existing policy includes actions such as:

- Increasing or decreasing benefits (health) or face amount (life)
- Changing premium payments on investment-based or annuity contracts
- Converting a whole life policy to extended term or reduced paid-up
- Any other change that affects the original benefit structure of the policy

Required Forms for Replacements

To process a replacement application, submit the following fully completed documents:

- Application (including any required supplemental pages)
- Authorizations (e.g., HIPAA, bank draft)
- Replacement Form (required for external replacements)*
  - Medicare Supplement
  - Life Insurance
  - Health Insurance: Requirements vary by state and product (refer to ADDS)
  - State-specific mandatory forms

* Required for external replacements and internal replacements on affiliates

Note: External replacements may require a telephone interview. See the Telephone Interview Process section for details.

Internal Replacement Review

For internal replacements, underwriting will also review:

- The applicant's medical history from claims records
- The claims loss ratio of the existing policy

Important Restrictions

- 1035 Exchanges are not accepted for new business.
- Bankers Fidelity cannot contact the applicant's previous carrier to cancel or alter existing coverage.
- The policyholder must notify their current carrier of cancellation before the effective date of any new policy issued by Bankers Fidelity.
- Bankers Fidelity is not liable for any financial loss due to failure to cancel or change existing coverage.

Duplicate Medicare Supplement policies are prohibited.

Reinstatement Guidelines

Reinstatement allows a lapsed policy to be reactivated under certain conditions. The rules vary by product type and lapse duration.

Health Insurance Reinstatement

- If the policy has lapsed but is within 3 months of the last paid-to date, it may be reinstated, subject to current underwriting requirements.
- If the lapse is more than 3 months beyond the last paid-to date, the policy cannot be reinstated.
  - The applicant must apply for new coverage instead.

Whole Life Insurance Reinstatement

- May be reinstated if the policy has lapsed and is within 60 months (5 years) of the last paid-to date.

Application Process

- The Proposed Insured must complete the appropriate reinstatement application.
- All underwriting requirements must be met within the 3 months before reinstatement.

Important Notes

- No coverage is in effect and no benefits are payable until the policy is officially reinstated.
- The effective date of a reinstated policy is the date the reinstatement is approved (excludes Life Insurance, which may follow different rules).

Open Enrollment

Eligibility

Begins on the first day of the month when the Proposed Insured is:

- Age 65 or older, and
- Enrolled in Medicare Part B
- If the applicant's birthday is on the first day of the month, Medicare Part B (and Medicare Supplement) coverage may begin one month earlier.
- Applications may be submitted up to 6 months prior to the Medicare Part B effective date.

Application Guidelines

- Do not answer health questions
- HIPAA form, replacement form, and telephone interview are not required
- For Under-65 Medicare Supplement applicants, a copy of both the Medicare card and driver's license is required, and applications must be completed in person.

  Note: Some states extend Open Enrollment to applicants under age 65. Refer to the state-specific application.

Tobacco Question Requirement (OE/GI)

For Open Enrollment or Guarantee Issue, the tobacco question must be answered in the following states:

Alabama	Georgia	Mississippi	West Virginia
Arizona	Indiana	Montana	Wyoming
Colorado	Iowa	Oklahoma	
Delaware	Kansas	South Dakota	
Dist. of Col.	Michigan	Texas	

Birthday Rule

The Birthday Rule allows Medicare Supplement policyholders in certain states to change plans or insurers without underwriting during a window around their birthday.

General Guidelines

- A new application is required.
- The effective date must be on or after the applicant's birthday (unless otherwise specified).
- Some states require an additional supplemental application page (e.g., LA, KY).

  Note: Tobacco rates may apply in some states.

States with Birthday Rule

Illinois (IL)

- Ages 65–75
- 45-day window starting on birthday
- May switch to a plan of equal or lesser value
- Must stay with the same company or affiliate
- Policy must be effective within 90 days of birthday

Indiana (IN)

- 60-day window
- Must switch to a different company or affiliate
- Must keep the same plan
- Effective date must be the first of the month at least 30 days after application

Kentucky (KY)

- 60-day window starting on birthday
- Must keep the same plan
- Must switch to a different company or affiliate

Louisiana (LA)

- 63-day window starting on birthday
- May switch to a plan of equal or lesser value
- Must stay with the same company or affiliate

Oklahoma (OK)

- 60-day window starting on birthday
- Must have had 90 days of continuous prior coverage
- May switch to a plan of equal or lesser value
- May switch to any company
- Policy must be effective within 60 days of birthday

Utah (UT)

- 60-day window starting on birthday
- May switch to a plan of equal or lesser value
- Must stay with the same company only (not affiliates)

Virginia (VA)

- 60-day window starting on birthday
- Must keep the same plan
- May switch to any company

63–Day Guarantee Issue (GI)

Key Points

- Applies to various qualifying events (see CMS's Choosing a Medigap Policy booklet)
- 90-day GI period in Wyoming
- Plan availability depends on the qualifying situation
- Required documentation:
  - Termination letter showing the end date and reason for loss of current coverage
- Do not answer health questions
- HIPAA form and telephone interview are not required
- Replacement form may be required (unless due to loss of group coverage)

Plan Availability

Bankers Fidelity offers the following Medicare Supplement plans:

- A, B, C, D, F, High-Deductible F, G, High-Deductible G, K

Availability Restrictions

- Plans D, G, and High-Deductible G:
  - Not available under GI for individuals eligible for Medicare Part A before Jan 1, 2020
- Plans C, F, and High-Deductible F:
  - Not available under GI for individuals eligible for Medicare Part A on or after Jan 1, 2020
- Plan N:
  - Not available under GI, except when using Trial Right upon joining a Medicare Advantage plan at initial eligibility

Medicare Part A eligibility is based on the earlier of:

- The Part A effective date, or
- The month the applicant turns 65

Acceptable Proof for Medicare Supplement Guarantee Issue

Losing group health coverage

Involuntary Termination:

Documentation from the employer, union, or carrier stating:

- Coverage was involuntarily lost
- The termination date (MM/DD/YYYY)
- The reason for termination

Voluntary Termination:

Documentation from the employer, union or carrier showing:

- The termination date of coverage
- Accepted in:
  AR, CO, ID, IL, IN, IA, KS, LA, MT, NJ, NM, OH, OK, PA, SD, TX, VA, WV

  TX: Only if the plan being left was primary to Medicare

Losing Medicare Advantage plan because plan is no longer being offered

A letter from Medicare or the Medicare Advantage plan stating the plan is no longer being offered and the termination date is required.

Losing or Discontinuing Medicare Advantage plan in trial period (Former Medicare Supplement Plan no longer available)

- Disenrollment letter from Medicare or the Medicare Advantage plan confirming disenrollment and the termination date is required.
- Proof of the plan the applicant previously had (i.e. letter from previous Medicare Supplement carrier stating plan, or ID card) or proof showing the applicant's previous plan is no longer available (i.e. letter from previous carrier, or information from the carrier website) and the termination date is required.

Losing Medicare Advantage plan in trial period (Joining when first eligible for Medicare)

Letter from Medicare OR Medicare Advantage confirming the disenrollment and the termination date is required.

Losing Medicare Select or Medicare Advantage plan due to moving out of service area

A letter stating the Proposed Insured has moved out of the area is required and termination date, proof of the coverage they had, and proof that the plan is not offered where they currently reside (i.e. a print out of the service area from the Medicare Select or Medicare Advantage plan's website) will be required.

Losing Medicare coverage through no fault of their own

Proof from Medicare or the current carrier the Proposed Insured is losing their coverage through no fault of their own and termination date is required.

Discontinuing Medicare Advantage plan for being misled

A letter from Medicare giving the Proposed Insured approval to leave the Medicare Advantage plan for being misled is required.

Loss of Medicaid (CO, KS, MT, TN, TX, UT)

A letter from Medicaid stating the Proposed Insured is losing their coverage and the termination date is required. The reason why they are losing coverage will have to satisfy the state requirements.

Understanding the Differences: Open Enrollment vs. 63-Day Guarantee Issue vs. Birthday Rule

Open Enrollment

- A one-time, 6-month window.
- Begins on the first day of the month when the applicant:
  - Turns age 65, or
  - First enrolls in Medicare Part B
- No health questions or underwriting required.

63-Day Guarantee Issue

- Applies to specific situations where an individual loses or terminates other health coverage outside of their Open Enrollment period.
- The applicant has 63 days from the loss of coverage to apply for a Medicare Supplement plan.
- Requires proof of termination but no health questions or underwriting.

Birthday Rule

- Available only in certain states.
- Allows existing Medicare Supplement policyholders to:
  - Switch plans or
  - Change insurers
- Must occur within a limited time frame surrounding the policyholder's birthday.
- Typically allows switching to a plan of equal or lesser value without underwriting.

Note: If an applicant qualifies for both Open Enrollment and Guaranteed Issue, Open Enrollment takes precedence, as it typically offers broader access to plans without medical underwriting, ensuring the applicant can select any available Medicare Supplement plan during the Open Enrollment Period period.

DECISION PROCESS

If an application is not approved, underwriting may make one of the following decisions instead:

Counteroffers & Rate Class Changes

Counteroffer Process

- The counteroffer will be sent to the agent via email.
- If the counteroffer is accepted, it will be formalized through an amendment that must be signed by the applicant.

Important Requirements

- A policy will not be considered in force until Bankers Fidelity receives the signed amendment.
- If the signed amendment is not returned within 15 days of being sent:
  - The application will be withdrawn.
  - A new application will be required for further consideration.

Returning the Signed Amendment

The signed amendment may be submitted via Email, Fax or Mail

Amendments

An amendment to the application will be issued when any of the following situations occur:

- A health question is left unanswered
- A question is answered incorrectly
- There is an error or unclear response regarding the date of birth or plan selection
- A change is made to the application but not initialed by the Proposed Insured
- A premium calculation error is identified
- A change results in an increase to the premium

Delivery of Amendments

- If the applicant's email or mobile number is provided, the amendment will be sent via DocuSign.
- If not, the amendment will be mailed to the agent for completion.

Premium Shortages

If the Shortage is within allowable limits

- The remaining balance can be paid by the client using one of the following methods:
  - Credit or debit card (over the phone)
  - Check (by mail)
- A notification letter will be mailed to the agent along with the policy
- If the additional premium is not received within 30 days, the policy will be:
  - Withdrawn, and
  - The initial premium refunded to the payor.

The policy will not be in force until the full premium is received.

If the Shortage Exceeds Allowable Limits the application will be considered Not in Good Order (NIGO) and cannot proceed until corrected.

Agents are not permitted to deduct premium shortages or policy fees from their commission.

Applications Not in Good Order (NIGO)

If an application is submitted with missing or incomplete information, the following process will apply:

During the Review Process

- The agent will be contacted to provide the necessary missing information.
- The agent has 30 calendar days from the application signed date to submit the required details.

If Information Is Not Received

- After 30 days, the application will be withdrawn as incomplete.
- A notification letter will be sent to both the applicant and the agent.
- Any premium paid will be refunded to the payor.

Withdrawn Applications

An application will be withdrawn if any of the following conditions apply:

- The Proposed Insured does not recall filling out the application.
- The application was filled out and signed by a third party without providing a binding Power of Attorney.
- The application was taken by an agent who was not licensed and appointed at the time of solicitation in the state of application.
- The Proposed Insured is unable or unwilling to complete the telephone interview.
- Additional forms requested by underwriting are not submitted within the required time frame.
- The Proposed Insured refuses or is unable to provide information about a medical condition for which a medication has been prescribed.
- The state where the application was signed does not match the applicant's state of residence.
- The application was not completed in person for under age 65 applications

Declined Applications

Notification Process

- If an application is declined, the Proposed Insured will be notified by mail.
- The agent will be copied via email.
- You may request the reason for the declination.

Disclosure of Declination Reasons

The method of disclosure depends on the source of the information used in the underwriting decision:

If the reason was disclosed on the application:

- The reason may be shared verbally with both the agent and the Proposed Insured.

If the reason came from a prescription drug search or telephone interview:

- The reason may be disclosed directly to the Proposed Insured verbally or via written request.

If the reason came from medical claims data or internal claims records:

- The reason may be disclosed directly to the proposed insured upon written request.

If the reason came from a doctor's letter, medical records, or direct physician communication:

- The reason can only be released to a physician of the Proposed Insured's choice.
- A written request is required, including:
  - The physician's name, address, and phone number
  - The Proposed Insured's signature

Privacy Notice

Important:

We will not disclose non-public personal health information (PHI) or any other private information to an agent unless the "Authorization for Release of Information to My Insurance Agent and/or Agency" form has been signed by the Proposed Insured.

Reopening Applications

A previously withdrawn or declined application may be reopened under specific circumstances:

Open Enrollment

- If the application was withdrawn due to missing requirements, it may be reopened within the 6-month Open Enrollment window once the requirements are submitted.
- This allows the applicant to retain the original coverage and effective date.

Guarantee Issue (GI)

- If withdrawn due to missing documentation verifying GI eligibility, the application may be reopened within the 63-day GI window once the documentation is provided.
- The applicant may retain the original coverage and effective date.

Returned Initial Premium

- If the initial premium was returned, the application may be reopened within 30 days of the effective date to reprocess the payment.
- This allows the applicant to keep the originally applied-for coverage and effective date.

Milliman Appeals

- If the applicant appeals information in the medical data report from Milliman and underwriting overturns the original decision, the application may be reopened.
- The new effective date must be:
  - No earlier than the date of approval, and
  - No more than 90 days from the original application date
- If the appeal is resolved after 90 days, a new application is required.

When Reopening Is Not Allowed

- Pending Requirements Not Met
- If the application was withdrawn due to pending requirements not being returned within 30 days of the initial request, it cannot be reopened.
- A new application must be submitted.

Policy ID Card Delivery

- A physical policy ID card will be mailed separately to the insured after the policy is issued.
- Medicare Supplement policies are the only plans that include the provision of ID cards.

Temporary ID Card Access

- While waiting for the physical card, agents can access a temporary ID card for their customer by:
  - Logging into ADDS
  - Using the App Tracker feature

Refunds

All refunds are issued directly to the payor in cases such as:

- Declined applications
- Incomplete submissions
- Cancellations, and similar scenarios

A full refund of the premium submitted with an application will be processed 21 days after the check is deposited, to allow time for the check to clear the bank.

Application status can be viewed at any time through ADDS.

Required Forms

Always use the most current, state-approved forms for the state in which the application is being signed.

- Current forms can be downloaded and printed from ADDS.
- Forms must be fully completed—all questions answered and blanks filled in.
- Incomplete forms will be returned to the agent with instructions for correction.

The following forms should be submitted to Underwriting:

Application

- Only current, state-approved versions are accepted.

Authorization for Drafts/Withdrawals/Charges

- Required for automatic bank draft or credit card payments.
- Include a voided check if paying by bank draft.

Family Billing Form

- Required when two or more policies are billed from the same account or on the same invoice.

HIPAA Authorization Form

- Required with every application, except for:
  - Open Enrollment
  - Guarantee Issue
  - Birthday Rule
  - Internal Replacements when not changing companies

Replacement Notice

- Required only if replacing coverage for:
  - All Medicare Supplement (except Open Enrollment)
  - All Life Insurance
  - Health Insurance (varies by state and product; refer to ADDS)

Authorization for Release of Information to My Insurance Agent and/or Agency

- Optional form. Required only if the applicant authorizes release of personal or medical information to their agent in the event of a decline or counteroffer.

The following forms should be left with the Proposed Insured regardless of whether an application is written:

Guide to Health Insurance for People with Medicare – Leave with all applicants age 65 and over applying for any health insurance product.

Life Insurance Buyer's Guide – Leave with all applicants for life insurance.

Notice to Applicant – Part One and Part Two – Leave with the Proposed Insured for all product applications.

Premium Receipt – Leave with the payor only if the initial premium is collected with the application.

Replacement Notice – Leave with the Proposed Insured when applicable.

Additional Product-Specific Multi-State Forms:

- **Accelerated Death Benefit Disclosure** required for Whole Life applications in:
  - AL, AR, IL, IN, KS, LA, MA, MI, MN, MS, MT, NE, NC, OH, OK, OR, PA, VA, WA

  A copy must be left with the Proposed Insured.

- **Birthday Rule Form required in:**
  - KY, LA, UT, WY

Additional State-Specific Forms:

Illinois

Medicare Supplement Checklist (for all replacement cases). Copy must be left with the Proposed Insured.

Kentucky

Medicare Supplement Comparison Form (for all replacement cases). Copy must be left with the Proposed Insured.

Maine

Unintentional Lapse Designation Form. This form must be completed and submitted on all products other than Medicare Supplement.

Pennsylvania

- Disclosure Statement (Cash Value Worksheet). Submit original to Underwriting; leave a copy with the Proposed Insured.
- Medicare Supplement Application Supplement.

South Carolina

Duplication of Insurance Form (required for all products other than Medicare Supplement applications if coverage duplicates existing insurance). Copy must be left with the Proposed Insured.

Utah

Extra Hazardous Activities Waiver (required for all Hospital Indemnity applications). Copy must be left with the Proposed Insured.

Virginia

Notice About Attained Age Rated Medicare Supplement Policies. Required for all Medicare Supplement applications; copy must be left with the Proposed Insured.

Washington

Extra Hazardous Activities Waiver and Pre-Existing Medical Conditions Waiver. Required for all Hospital Indemnity applications; copies must be left with the Proposed Insured.

Policy for Agents Writing Business on Themselves or Relatives

Agents are permitted to write policies for themselves or their relatives, provided the following product types are involved:

- Cancer Insurance
- Hospital Indemnity Plans (HIP)
- Short-Term Care (STC)
- Medicare Supplement (Med Supp)
- Life Insurance

All standard underwriting and application procedures must still be followed when writing business on oneself or a relative.

The Strength of Experience

At Bankers Fidelity, we conduct our business according to a strong set of guiding principles.

For more than 70 years, we have been honored to provide tens of thousands of Americans with valuable, customer-focused insurance products.

Our commitment to fair and fast payment of claims has earned us a reputation for delivering quality service to our policyholders and their families.

You can rely on our reputation as a Company that consistently makes good on its promises to every single policyholder.

Bankers Fidelity is rated A- (Excellent) by A.M. Best Company.

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