# NEW ERA LIFE INSURANCE COMPANY

## APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Seniors with Medicare Parts A and B

## SECTION 1 – CHOICE OF COVERAGE

Please check the box for your choice of coverage:

- ☐ **STANDARD PLAN A**
- ☐ **STANDARD PLAN C**
- ☐ **STANDARD PLAN F**
- ☐ **STANDARD PLAN G**
- ☐ **STANDARD PLAN N**

## SECTION 2 – APPLICATION INFORMATION

A copy of this application will be returned to you, for your records, along with your policy, when you are enrolled.

**Please copy the information from your Medicare card here** ⇩

| NAME OF BENEFICIARY (Applicant) | CLAIM NUMBER | SEX |
|---|---|---|
| | | |
| **IS ENTITLED TO** | **EFFECTIVE DATE** | |
| HOSPITAL INSURANCE (PART A) | | |
| MEDICAL INSURANCE (PART B) | | |

Requested effective date, or end date of prior Medicare supplement, if replacing ____ / ____ / _____

Name (as it appears on your Medicare card) _____

Social Security Number | | | | | | | | | | Date of Birth _____

Home Address, Apt. No., Suite No. _____

City _____ County _____ State _____ Zip _____

E-mail Address: _____

Home Telephone Number _____

Billing Address, (if different from home address) _____

City _____ County _____ State _____ Zip _____

Care of/Attention _____

## SECTION 3 – BILLING INFORMATION

☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ PAC (Checking Account Deduction Only)

Please indicate a preferred draft date (excluding the 29th, 30th, 31st) _____

*Affix check here. Please make check or money order for premium payable to New Era Life Insurance Company.*

**No agency checks are accepted.**

**Applicant: Please return application to agent or to the address below:**

New Era Life Insurance Company, Underwriting Department
P.O. Box 4884
Houston, Texas 77210-4884

## SECTION 4 – HEALTH HISTORY

**THIS SECTION MUST BE COMPLETED BY APPLICANT**

IF APPLYING DURING THE OPEN ENROLLMENT PERIOD OR IF YOU ARE A GUARANTEED ISSUED ELIGIBLE PERSON, DO NOT COMPLETE THIS SECTION (Skip to Section 5)

If the answer to any of the following questions is "Yes", you are not eligible for coverage.
Check the box next to any conditions that apply to you.

| | Yes | No |
|---|---|---|
| 1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair, cane or walker for any daily activity? | ☐ | ☐ |
| 2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer? | ☐ | ☐ |
| 3. Within the past 2 years, have you been advised to have surgery which has not yet been done? | ☐ | ☐ |
| 4. Within the past 5 years, have you ever consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions: | | |
| a. Heart or vascular conditions including but not limited to heart attack, open heart surgery, placement of a stent, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, peripheral vascular disease, coronary artery disease, irregular heartbeat or stroke? | ☐ | ☐ |
| b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder, any neurological disorder or other senility disorder? | ☐ | ☐ |
| c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, emphysema or use of inhalers, nebulizers or oxygen? | ☐ | ☐ |
| d. Internal cancer, leukemia, melanoma, Hodgkin's disease, insulin dependent diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea) or amputation? | ☐ | ☐ |
| 5. In the past 12 months have you had placement of a pacemaker or had a joint replacement? | ☐ | ☐ |

**Applicant's Initials:** _____

## SECTION 5 – MEDICAL INFORMATION

Name of Primary Care Physician _____ Telephone (_____) _____

Address _____

## SECTION 6 – GENERAL INFORMATION

ANSWER ALL QUESTIONS IN THIS SECTION TO THE BEST OF YOUR KNOWLEDGE

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Do you meet the definition of an Eligible Person as defined in this application? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

If yes, what is the effective date? _____

Are you covered for medical assistance through the state Medicaid program? {NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.} ☐ Yes ☐ No

If yes; will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

If yes; do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

If you had coverage from any Medicare Plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START ___/___/___ END ___/___/___

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No

Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

Did you drop a Medicare supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No

Do you have another Medicare supplement policy in force? ☐ Yes ☐ No

If so, with what company, and what plan do you have? _____

If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Yes ☐ No

If so, with what company and what kind of policy? _____

If so, what are your dates of coverage under the other policy? START ___/___/___ END ___/___/___ (If you are still covered under the other policy, leave "END" blank.)

**TOBACCO USAGE**

Have you used any form of tobacco within the past 5 years? ☐ Yes ☐ No

I acknowledge that misrepresentation of this information may render the policy null and void.

Date:_____ _____

Applicant's Signature

## SECTION 7 – CONDITIONS OF APPLICATION

**Please read the following carefully**.

1. I agree to submit the premium required for the plan requested with this application. Such premium will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. New Era will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B or when I am an Eligible Person for Guaranteed Issue. If my application is not received during the open enrollment period, New Era has the right to reject my application. If New Era rejects my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that if New Era rejects my application, under no circumstances will any New Era benefits be payable. ***Cashing of my check by New Era does not constitute approval of my application.***
3. If my application is accepted, this application will become part of the agreement between New Era and myself.
4. The selling agent has no authority to promise me coverage or to modify New Era underwriting policy or terms of any New Era coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that New Era may void all coverage from the original effective date of the policy for intentional material misstatements or omissions.

## SECTION 8 – AUTHORIZATION AND AGREEMENTS

### Notice to Applicant

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

### Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization for Your Files If Requested. (Read all five paragraphs and sign below)

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of New Era any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize New Era, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable New Era to process claims. A photocopy shall be valid.
- I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), the Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare," and "Outline of Medicare Supplement Coverage and Premium Information" as required. I understand that receipt of money with this application does not create New Era coverage. Coverage will come into effect only if this application is approved by New Era.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or intentional material misrepresentation in the Application may result in loss of coverage under the policy.

**Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits**

**X** _____ _____

Applicant's Signature | Date of Signature

## MEDICARE SUPPLEMENT PLAN REPLACEMENT WORKSHEET

**Agents please complete if replacing other existing Medicare coverage**

**Insured**

| Name | SS# |
|---|---|
| Proposed Plan | |

**Old Plan**

| Company Name | |
|---|---|
| Expiration Date | Contract No. |

**Benefit Comparison**

See reverse side for New Era benefits. Check benefits that apply.

| Write in benefits not listed. | Old Plan | New Era Plan |
|---|---|---|
| Part A Deductible | | |
| Part A Coinsurance | | |
| Additional Hospital Days | | |
| Skilled Nursing Facility Coinsurance | | |
| Hospice | | |
| Part B Deductible | | |
| 20% Part B Coinsurance | | |
| 50% Part B Coinsurance (Nervous and Mental) | | |
| Part B Excess Charges at 100% | | |
| Prescription Drugs | | |
| Emergency Travel Benefits Outside the U.S. | | |
| At-Home Recovery (pre June 1, 2010 Standardized plans) | | |
| Preventive Medical Care (pre June 1, 2010 Standardized plans) | | |
| 10% or Greater Premium Savings | | |

Does this plan have benefits clearly and substantially better than those of the old plans? _____
If yes, explain below:

Agent Signature _____ Agent No. _____ Date _____

## OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION FOR SENIORS

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of New Era Life Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize New Era to initiate debits (and/ or corrections to previous debits) from my account with the financial institution indicated for payment of my New Era premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no obligation whatsoever even though such dishonor results in forfeiture of insurance.

**Please attach a blank check marked "VOID".**

| Insured | | Social Security Number | |
|---|---|---|---|
| | | Bank Name | |
| **X** | Date | **X** | Date |

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

**PRIORITY PROCESSING**

COMPLETE THIS FORM TO ENROLL IN THE OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION FOR SENIORS.

**INCLUDE A BLANK CHECK MARKED "VOID".**

**A DEPOSIT SLIP IS NOT ACCEPTABLE.**

**NEW ERA LIFE INSURANCE COMPANY**

**SENIOR SERVICES TOLL-FREE NUMBER**

Monday – Friday
8:00 a.m. to 5:00 p.m.

(877) 368-4691

## FOR AGENT ONLY

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

| Date | Name of Policy | Name and Address of Insurance Company |
|---|---|---|
| From: Mo./Yr. _____ | _____ | Name: _____ |
| To: Mo./Yr. _____ | _____ | Address: _____ |
| | _____ | City/State: _____ |

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage and a disclosure statement for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

SIGNED AT _____

Agent's Signature | Date of Signature | (City and State)

Print Agent's Name | Agent No.

Street Address | Telephone No.

City | State | ZIP

E-mail Address:

*For split commissions, please add name and agent no.*

Premium Amount $_____

Agent Name

Agent No.

Send Policy To: ☐ Agent ☐ Insured

**SENIOR SERVICES TOLL-FREE NUMBER**

Monday - Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)

(877) 368-4691

## NEW ERA LIFE INSURANCE COMPANY

### PREMIUM RECEIPT

Date _____ Amount _____

Name _____

Social Security Number _____

Account _____ Check Number _____

Policy Description _____

Received by _____

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.

# ELIGIBLE PERSONS FOR GUARANTEED ISSUE

**ELIGIBLE PERSON** means an individual who:

Is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or ceases to provide all health benefits to the individual because the individual leaves the plan.

Is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated; or

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

Is enrolled with an entity listed in subparagraphs (i) -- (iv) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

(i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);

(ii) A similar organization operating under demonstration project authority, effective for periods before April 1,1999;

(iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(iv) An organization under a Medicare Select policy.

Is enrolled under a Medicare Supplement policy and the enrollment ceases because:

(a) Of the insolvency of the issuer or bankruptcy of the non-issuer organization;

(b) Of other involuntary termination of coverage or enrollment under the policy; or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Is enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

Upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in Medicare Advantage plan under Part C of Medicare, or in a PACE program under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

Is enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare part D along with the application for a Medicare Supplement plan of A, B, C, F (including F with high deductible), K or L that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.

**NEW ERA LIFE INSURANCE COMPANY**
**NEW ERA LIFE INSURANCE COMPANY of the MIDWEST**

P.O. Box 4884 • Houston, Texas 77210 • (800) 713-4680

# AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION

Applicant / Primary Insured Name _____ Policy / Certificate # (if applicable) _____ Phone # _____

Address (Street, City, State, Zip) _____

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist, Pharmacy Benefit Manager or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: New Era Life Insurance Company (NEL) or New Era Life Insurance Company (NEM) or its agents, employees, designees, or representatives, including my NEL or NEM agent or broker.

Purpose of this Authorization: By signing this form, you will authorize NEL or NEM to use and/or disclose your Protected Health Information (PHI) to determine if your application will be approved for health insurance or that you are eligible for benefits. This authorization is a condition of your approved application for our health insurance or your eligibility for benefits.

You also will authorize NEL or NEM to obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

Effect of Declining: If you decide not to sign this authorization, we may decline to approve your application for health insurance or to provide benefits.

This authorization may facilitate our consideration of a claim. If you decide not to sign this authorization, it may delay the processing of a claim.

Effect of Granting this Authorization: The PHI to be used and/or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any NEL or NEM coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to: New Era Life Insurance Company or New Era Life Insurance Company of the Midwest, P.O. Box 4884, Houston, TX. 77210-4884.

I understand that revocation of this authorization will not affect any action NEL or NEM took in reliance on this authorization before NEL or NEM received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

Print Name of Applicant or Claimant _____ Signature of Applicant or Claimant (parent if minor) _____ Date ____/____/____

If this authorization is signed by a personal representative, on behalf of the individual, complete the following:

Personal Representative: Print Name _____ Please indicate Representative's relationship to Applicant/Insured and briefly describe Representative's authority to act for Applicant/Insured. _____

Signature _____ Date _____/____/_____

A photocopy of this authorization is as valid as the original, and you and your NEL or NEM agent or broker are entitled to receive a copy of this form.

NOTICE TO APPLICANT REGARDING
REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR
MEDICARE ADVANTAGE

New Era Life Insurance Company
P.O. Box 4884
Houston, Texas 77210-4884

Save This Notice! IT May Be Important To You In The Future!

According to your application or information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by New Era Life Insurance Company. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

(Check one):

☐ Additional benefits,
☐ Same benefits but lower premiums,
☐ Fewer benefits and lower premiums,
☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____
☐ Other, (please specify)_____ .

(1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will reduce any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy to the extent such time was spent under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

(4) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

| | |
|---|---|
| _____ | _____ |
| Signature of Agent | Signature of Applicant |
| _____ | _____ |
| Print Agent Name | Print Applicant Name |
| _____ | _____ |
| Print Agent Address | Date |

WHITE COPY: To be sent to Home Office with Completed Application. Yellow: Given to Applicant