

**APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE**

**SECTION I. PROPOSED INSURED INFORMATION**

Applicant Name *(exactly as it appears on your Medicare Card)*

First Name	Middle Initial	Last Name
Resident Address		Phone <i>(with area code)</i>
City		Date of Birth <i>(MM/DD/YYYY)</i>
State	Zip Code	Age
Mailing Address <i>(if different from Resident Address)</i>		Email Address
City		Male <input type="checkbox"/> Female <input type="checkbox"/>
State	Zip Code	Social Security Number <i>(requested, but not required)</i>
Medicare Card Beneficiary Identification Number		

**SECTION II. PLAN AND PREMIUM INFORMATION**

**Plan Applied For:**

Basic ☐ Copayment ☐ Extended Basic\* ☐ Extended Basic 2020 ☐ High Deductible ☐

**Optional Riders (Basic Plan Only):**

☐ Part A Deductible ☐ Part B Deductible\* ☐ Part B Excess Charges ☐ Preventive Medical Care

\*Available only if you are Medicare eligible before January 1, 2020.

Requested Policy Effective Date

Modal Premium \$	Policy Fee \$
Premium Collected \$	Payment Method: Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/>
Payment Mode: Monthly <input type="checkbox"/> (Bank Draft ONLY)	Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/>

**SECTION III. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS**

- |   |  |
|---|--|
| 1. Within the past 12 months, have you used any tobacco or nicotine products, including cigarettes, cigars, eCigarettes, vape, chewing tobacco, pipe, nicotine gum/patch? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Are you covered under Medicare Part A?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If NO, what is your future Part A eligibility date? (MM/DD/YYYY) _____  |  |
| If YES, what is your Part A effective date? (MM/DD/YYYY) _____  |  |
| 3. Are you covered under Medicare Part B?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If NO, what is your future Part B eligibility date? (MM/DD/YYYY) _____  |  |
| If YES, what is your Part B effective date? (MM/DD/YYYY) _____  |  |
| 4. Have you enrolled in Medicare Part B more than once?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Are you applying during a guaranteed issue period? (If YES you must attach proof of eligibility).  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)?   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| IF YES, please check the box that applies                      Disability <input type="checkbox"/> End Stage Renal Disease (ESRD) <input type="checkbox"/>                |  |

**SECTION IV. HEALTH QUESTIONS**

**DO NOT ANSWER THESE HEALTH QUESTIONS IF YOU ARE APPLYING DURING OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD.**

- |   |  |
|---|--|
| 1. Height ( <i>Feet and inches</i> ): _____ Weight ( <i>Pounds</i> ): _____   |  |
| 2. Are you bedridden, confined to a wheelchair, or do you require the assistance of a motorized mobility device, or have you had any amputation caused by disease?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Are you currently hospitalized, in a nursing home or assisted living facility, or have you been hospitalized three or more times in the past two years?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Are you currently receiving any occupational, speech, or physical therapy, or are you currently using the services of a home healthcare agency?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Have you been diagnosed or treated by a physician to have surgery (including cataract or joint replacement surgery), medical tests, infusions, or therapy that has not been performed? (This excludes mammograms, pap tests, colonoscopies, or PSA test which were advised for routine screening purposes only.)   | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. Have you been medically diagnosed or treated by a physician for any of the following:  |  |
| a. Parkinson's disease, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia, or any other cognitive disorder?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| b. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection? Please answer NO to this question if Minnesota law applies that protects you from disclosure of a test to detect HIV which was administered to you at the time you were: (a) a criminal offender or crime victim who was exposed to or had contact with an offender's bodily fluids during the commission of a crime that was reported to law enforcement officials; (b) an emergency personnel who was tested as a result of performing emergency medical services; (c) a corrections employee; or (d) an employee of a secure treatment facility. | Yes <input type="checkbox"/> No <input type="checkbox"/> |

**SECTION IV. HEALTH QUESTIONS (continued)**

- c. Chronic kidney disease stage 3-5 or kidney insufficiency, or renal failure requiring dialysis? Yes ☐ No ☐
- d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic pulmonary condition, or any medical condition requiring the use of oxygen? Yes ☐ No ☐
- e. Systemic lupus, scleroderma, or myasthenia gravis? Yes ☐ No ☐
- f. An organ transplant or been diagnosed or treated by a physician to have an organ transplant (excluding cornea transplants)? Yes ☐ No ☐
- g. Chronic hepatitis or cirrhosis of the liver? Yes ☐ No ☐
- h. Cardiac defibrillator implanted? Yes ☐ No ☐
7. Within the past two years, have you been diagnosed by a physician with any of the following:
- a. Heart attack, cardiac angioplasty, bypass surgery, or stent placement or replacement? Yes ☐ No ☐
- b. Vascular angioplasty, endarterectomy, or implantation of a pacemaker? Yes ☐ No ☐
- c. A stroke or transient ischemic attack (TIA)? Yes ☐ No ☐
8. Within the past two years have you been treated for, or been advised by a physician to have treatment for:
- a. Alcoholism or drug abuse? Yes ☐ No ☐
- b. Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐
- c. Arthritis that restricts mobility? Yes ☐ No ☐
9. If you have diabetes or take medication to control your blood sugar, please answer each of the following questions (a-d); otherwise, answer each question NO.
- a. Have you been diagnosed or treated by a physician to take more than fifty (50) units of insulin daily? Yes ☐ No ☐
- b. Do you take three (3) or more medications (oral or injections) to control your blood sugar? Yes ☐ No ☐
- c. Do you take four(4) or more medications to control your high blood pressure? Yes ☐ No ☐
- d. Have you been diagnosed with or treated by a physician for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney disease, kidney failure, stroke, TIA, congestive heart failure, or any heart disorder? Yes ☐ No ☐

**SECTION V. CONSIDERATION HEALTH QUESTIONS**

**DO NOT ANSWER THESE HEALTH QUESTIONS IF YOU ARE APPLYING DURING OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD.**

10. Are you currently receiving, or have you been advised by a medical professional to receive injections in a physician's office? Yes ☐ No ☐
11. Within the past two years have you been treated for or been diagnosed by a physician to have treatment for:
- a. Coronary artery disease, angina, aortic or cardiac aneurysm, cardiomyopathy, congestive heart failure, heart valve disorder, atrial fibrillation, or other heart rhythm disorder? Yes ☐ No ☐
- b. Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, or carotid artery disease? Yes ☐ No ☐
- c. Degenerative bone disease, spinal stenosis, or rheumatoid arthritis? Yes ☐ No ☐
- d. Any mental or nervous disorder requiring treatment by a psychiatrist? Yes ☐ No ☐

You must explain any yes answers above and provide dates and details.


#### SECTION VI. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)	
Date <b>Originally</b> Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date <b>Originally</b> Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date <b>Originally</b> Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date <b>Originally</b> Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date <b>Originally</b> Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date <b>Originally</b> Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

## SECTION VII. PREVIOUS OR EXISTING COVERAGE INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐
- (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐
- (c) If YES, indicate your effective date (MM/DD/YYYY). \_\_\_\_\_

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)

If YES, answer (a) – (b) below.

- (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐
- (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐
3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? Yes ☐ No ☐

(For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)

If YES, answer (a) – (g) below.

- (a) Name of Company \_\_\_\_\_

Plan Type & Policy/Certificate No \_\_\_\_\_

Company Telephone Number \_\_\_\_\_

Coverage Dates (MM/DD/YYYY):

START DATE \_\_\_\_\_

(if you are still covered under this plan, leave end date blank)

END DATE \_\_\_\_\_

- (b) 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 ☐

If YES, have you received a copy of the replacement notice? Yes ☐ No ☐

- (c) Reason for termination/disenrollment? \_\_\_\_\_

- (d) Planned date of termination/disenrollment? (MM/DD/YYYY) \_\_\_\_\_

- (e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐

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

- (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

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

If YES, answer (a) – (d) below.

- (a) Name of Company \_\_\_\_\_

Plan Type & Policy/Certificate No \_\_\_\_\_

Company Telephone Number \_\_\_\_\_

Issue Date (MM/DD/YYYY) \_\_\_\_\_

- (b) Do you intend to replace your current Medicare supplement policy with this policy? Yes ☐ No ☐

- (c) Indicate termination date (MM/DD/YYYY). \_\_\_\_\_

- (d) Have you received a copy of the replacement notice? Yes ☐ No ☐

**SECTION VII. REPLACEMENT QUESTIONS (continued)**

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐  
If YES, answer (a) – (c) below.
- (a) Name of Company \_\_\_\_\_  
Plan Type & Policy/Certificate No \_\_\_\_\_  
Company Telephone Number \_\_\_\_\_  
Coverage Dates (MM/DD/YYYY): \_\_\_\_\_ START DATE \_\_\_\_\_  
(if you are still covered under this plan, leave end date blank) END DATE \_\_\_\_\_
- (b) Reason for termination/disenrollment? \_\_\_\_\_
- (c) Planned date of termination/disenrollment (MM/DD/YYYY)? \_\_\_\_\_

**SECTION VIII. AGENT CERTIFICATION**

Agents shall list any other health insurance policies they have sold to the applicant.

- (1) List policies sold which are still in force.

Name of Company \_\_\_\_\_

Policy/Certificate Number \_\_\_\_\_

Description of Benefits \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_

Name of Company \_\_\_\_\_

Policy/Certificate Number \_\_\_\_\_

Description of Benefits \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_

- (2) List policies sold in the past five (5) years which are no longer in force.

Name of Company \_\_\_\_\_

Policy/Certificate Number \_\_\_\_\_

Description of Benefits \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_

Name of Company \_\_\_\_\_

Policy/Certificate Number \_\_\_\_\_

Description of Benefits \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_

Name of Company \_\_\_\_\_

Policy/Certificate Number \_\_\_\_\_

Description of Benefits \_\_\_\_\_

Effective Date of Coverage \_\_\_\_\_

**SECTION IX. IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- The benefits and premiums under your Medicare Supplement Insurance 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 policy will be reinstated if requested within 90 days of losing Medicaid eligibility. Upon such reinstituted policy (1) there is no additional waiting period with respect to treatment of preexisting conditions; (2) coverage is provided which is substantially equivalent to coverage in effect before the suspension; and (3) premiums are classified on terms that are at least as favorable to the policyholder as the premium classification terms that would have been applied to the policyholder had coverage not been suspended.
- Counseling services may be available in Minnesota to provide advice concerning medical assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs) and Specified Low-Income Medicare Beneficiaries (SLMBs).

**SECTION X. ELECTRONIC AND/OR TELEPHONIC INSTRUCTIONS.**

Authorization is requested by the Company to act on electronic and/or telephonic instructions from the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine and these procedures have been followed (Check One).

- ☐ I authorize the Company to act on electronic and/or telephonic instructions.
- ☐ I DO NOT authorize the Company to act on electronic and/or telephonic instructions.

Authorization is requested by the Company for the electronic delivery of statements and other documents (Check One).

- ☐ I authorize the Company to electronically deliver statements and other documents. I do have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address.
- ☐ I DO NOT authorize the Company to electronically deliver statements and other documents.

## SECTION XI. CERTIFICATION

**THIS PROVISION DOES NOT APPLY DURING OPEN ENROLLMENT AND GUARANTEED ISSUE WHEN MEDICAL UNDERWRITING IS PROHIBITED.**

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. **Unless I am applying during an open enrollment or guaranteed issue period, I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.**

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a *"Guide to Health Insurance for People with Medicare."*

Signed at:

\_\_\_\_\_ State

\_\_\_\_\_ Applicant's Signature

\_\_\_\_\_ Date

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Agent Writing Number

\_\_\_\_\_ Agent's Signature

\_\_\_\_\_ Date

Policy Mailing Preference:

☐

Mail to Agent

☐

Mail to Applicant

## SECTION XII. ANTICIPATED LOSS RATIO DISCLOSURE

Notice: This disclosure is required by Minnesota law. This policy is expected to return on average 65.0% percent of your premium dollar for health care. This means that on the average, a contract holder may expect that at least \$65.00 of every \$100.00 in premium payments will be returned as benefits to the contract holder over the life of the contract. The lowest percentage permitted state law for this policy or certificate is 65.0%.



**NOTICE TO APPLICANT REGARDING REPLACEMENT  
OF MEDICARE SUPPLEMENT INSURANCE**

**LUMICO LIFE INSURANCE COMPANY**

**Home Office: 237 East High Street, Jefferson City, Missouri 65101**

**Medicare Supplement Administrative Office: P. O. Box 10874, Clearwater, Florida 33757-8874**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE**

According to your application, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Lumico Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT:**

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

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ Other (please specify) \_\_\_\_\_

Health conditions which you may presently have (preexisting 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.

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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 company 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, review it carefully to be certain that all information has been properly recorded.

**This section does not apply during a guaranteed issue period.**

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

\_\_\_\_\_  
Signature of Agent, Broker or Other Representative

\_\_\_\_\_  
Typed Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT:**

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- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ Other (please specify) \_\_\_\_\_

Health conditions which you may presently have (preexisting 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.

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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 company 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, review it carefully to be certain that all information has been properly recorded.

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\_\_\_\_\_  
Signature of Agent, Broker or Other Representative

\_\_\_\_\_  
Typed Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

If your client is eligible for guaranteed issue based on one of the criteria shown below, **you must submit the acceptable proof of eligibility with the application.**

Minnesota Guaranteed Issue Checklist	Plans Available for Policy Effective dates on or after 1/1/2020 (if offered)
<p><b><u>Employer Coverage</u></b></p> <p><input type="checkbox"/> The individual is enrolled under an employee welfare benefit plan that supplements the benefits under Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual. <i>**Voluntarily terminating employer group coverage is <b><u>not</u></b> a Guaranteed Issue trigger.</i></p> <p><b><u>Acceptable Proof:</u></b> A letter from the employer reflecting the date of the loss of coverage <b><u>and</u></b> the reason for the loss of coverage for all individuals covered. <b><i>(Please note: a Certificate of Creditable Coverage does <u>not</u> typically indicate the reason for the loss of coverage.)</i></b></p>	
<p><input type="checkbox"/> Enrolled in a Medicare risk contract, health care prepayment plan, cost contract, Medicare Select plan, Medicare Advantage plan, Program of All-Inclusive Care for the Elderly (PACE) or a similar organization; and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual.</p> <p><b><u>Acceptable Proof:</u></b></p> <ul style="list-style-type: none"> <li>▪ A copy of the personalized letter from the Health Plan/Company indicating they are leaving the Medicare program, or the plan will no longer service the area/region, or the person has moved outside of the coverage area.</li> <li>▪ A copy of the report from the state's Department of Insurance documenting a violation of a policy provision and/or misrepresentation.</li> </ul>	<p>Basic Plan plus any combination of the Part A Deductible rider, Part B Excess Charges rider, and the Medicare Part B Rider*.</p>
<p><input type="checkbox"/> Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material marketing misrepresentation.</p> <p><b><u>Acceptable Proof:</u></b> A copy of the report from the state's Department of Insurance documenting the violation or misrepresentation.</p>	<p>*For "Newly Eligible" applicants, the Part B Deductible Rider cannot be sold</p>
<p><input type="checkbox"/> Enrolled under a Medicare Supplement policy, terminates that coverage and enrolls for the first time in a Medicare Advantage, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment.</p> <p><b><u>Please note: the client must go back to their previous Medicare Supplement carrier as guaranteed issue, if the plan is still available. If the previous carrier no longer issues coverage, the applicant is GI with any carrier.</u></b></p> <p><b><u>Acceptable proof:</u></b> A copy of the Policy Schedule Page or ID Card, or other documentation for the previous Medicare Supplement provider that includes the effective date, plan and termination date <b><u>and</u></b> a copy of the personalized disenrollment letter from the Medicare Advantage company. (If the disenrollment letter doesn't include the effective date, provide a copy of the ID card.)</p>	

<p><input type="checkbox"/> Upon first becoming eligible for benefits under Part B, enrolls in a Medicare Advantage or PACE provider plan and then disenrolls by not later than 12 months after the effective date.</p> <p><b><u>Acceptable Proof:</u></b> A copy of the personalized disenrollment letter from the Medicare Advantage Company <b><u>and</u></b> a copy of the ID Card or other personalized document showing the effective date of the plan.</p>	<p>Any Medicare Supplement Plan or riders offered by the insurer</p> <p>Any plan with a benefit or rider paying the Part B Deductible is <b><u>NOT</u></b> available for “Newly Eligible” applicants</p>
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#### Definition of Newly Eligible:

An applicant is deemed Newly Eligible if they meet BOTH of the following conditions:

- (a) Applicant was born ***on or after*** 1/1/1955 **AND**
  - (b) Applicant first enrolled in Medicare Part A on or after 1/1/2020
- \*\*Exception - If an applicant was born on 1/1/1955 and has a Part A effective date of 12/1/2019 – the applicant is deemed Newly Eligible.**



Medicare Supplement  
Administration  
PO Box 10875  
Clearwater, FL 33757-8875

Office: 1-855-774-4491  
Fax: 1-816-701-2549  
Online: lumico.com

## ELECTRONIC PAYMENT AUTHORIZATION FORM

Insured Name: \_\_\_\_\_

Insurance Policy Number: \_\_\_\_\_

### Sign and date this authorization below

As a convenience to me, I hereby request and authorize you to pay and charge to my bank account checks drawn by and payable to the order of Lumico Life Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of Lumico Life Insurance Company to sign such checks. I agree that your rights in respect to each such check shall be the same as if it were a check drawn by you and signed personally by me. 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 check. I further agree that if any such check be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

Please indicate below when you would like your account drafted. Many of our customers have requested the option to pay their premiums on the same day they receive Social Security or SSI payments. The options below allow you to select the date that best fits your needs. You may select any option regardless of whether or not you receive Social Security.

### Section 1 – Select one of the following date options

#### Initial Premium Payment: **(choose one)**

Same as Subsequent Premium Payments date below, on or after the requested Effective Date  
On the Policy Issue Date  
Paid by enclosed check

#### Subsequent Premium Payments: **(choose one)**

1<sup>st</sup> day of the Month

3<sup>rd</sup> day of the Month

2<sup>nd</sup> Wednesday of the Month

3<sup>rd</sup> Wednesday of the Month

4<sup>th</sup> Wednesday of the Month

(If the selection above falls on a weekend or holiday, deductions are scheduled for the prior business day)

Other, please specify a day of the month from the 1<sup>st</sup> to 28<sup>th</sup> \_\_\_\_\_  
(if this date falls on a weekend or holiday, deduction will be on the next business day)

### Section 2 – Select one of the payment options and complete account information (or attach a Void check)

Checking Savings

Accountholders Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Attach void check here

or complete information below

Accountholders Name: \_\_\_\_\_

Branch/Bank Name: \_\_\_\_\_

Routing number: \_\_\_\_\_

Account Number: \_\_\_\_\_