The EPIC Life Insurance Company
A WPS Company

WPS HEALTH INSURANCE

mywpsmedicare.com

FOR USE WITH EFFECTIVE DATES OF 1/1/2024 OR LATER

Please use the postage-paid envelope provided or mail completed application to:

The EPIC Life Insurance Company—Attn MMS Sales
1717 W. Broadway | P.O. Box 8190 | Madison, WI 53708-8190 Or fax this completed document to 1-608-223-3639

MEDICARE SUPPLEMENT PLAN ENROLLMENT APPLICATION

INSTRUCTIONS: You may not apply more than three (3) months prior to becoming eligible for coverage. Please complete all information requested on this application and mail this entire form to the address above. If application is being completed through an agency, the agent must complete and submit the agency form (section 10 of this application). You must have Medicare Parts A and B to enroll. If you have other Medicare supplement insurance that you don't intend to cancel, you are not eligible for this Medicare supplement plan.

Reason for application: ❍ Initial enrollment ❍ Re-enrollment ❍ Changing plans

1. APPLICANT INFORMATION

Last name_____ First _____ Middle _____

Date of birth_____ Sex _____

Home address _____

City _____ County _____ State _____ ZIP code _____

Mailing address (if different)_____

City _____ County _____ State _____ ZIP code _____

Telephone number (_____) _____

Email address _____

Medicare number _____

Medicare Part A effective date _____ Medicare Part B effective date _____

Is anyone who resides in your household* already enrolled in or currently applying for an EPIC Medicare supplement?
❍ Yes ❍ No

If yes, household member's full name _____

Household member's Medicare number_____

Household member's effective date of EPIC Medicare supplement policy _____

2. PLAN EFFECTIVE DATE

If EPIC approves you for coverage under this Medicare supplement policy, the policy's effective date will be the latest of:

A. The first day of the calendar month in which you become enrolled in Medicare Part B; or

B. The first day of the calendar month following the date of EPIC approval; or

C. Requested effective date _____/01/_____ (must be the first of the month)

*Household: Two or more individuals who reside together in the same dwelling. For purposes of this definition, "dwelling" means a single home, condominium unit, or apartment unit within an apartment complex.

3. PLAN SELECTION

Plans available

Highest coverage available

❑ **Plan G** - Basic Benefits, Part A Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency, Medicare Part B Excess Charges (100%)

❑ **Plan N** - Basic Benefits, Part A Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency, Part B Coinsurance (100%) less a $20 copay per office visit and a $50 copayment for ER

Lowest coverage available

❑ **Plan B** - Basic Benefits, Part A Deductible

❑ **Plan A** - Basic Benefits

Additional plans only available to applicants eligible for Medicare before 1/1/2020

❑ **Plan F** - Basic Benefits, Part A & B Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency, Medicare Part B Excess Charges (100%)

❑ **Plan C** - Basic Benefits, Part A & B Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency

4. GUARANTEED ACCEPTANCE

Please answer the following questions to determine whether your acceptance is guaranteed, without answering health questions.

A. Did you turn age 65 in the last six months? ..... ❍ Yes ❍ No

B. Did you enroll in Medicare Part B within the last six months? ..... ❍ Yes ❍ No

If yes, what is the Medicare Part B effective date? _____/_____/_____

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 proceed to section 6.

If you answered yes to questions A or B above, your acceptance is guaranteed, and you should not answer health questions. Please proceed to section 6. If you answered no to questions A or B, and are not losing other coverage, please proceed to section 5 to answer health questions.

There are other scenarios that may qualify you for guaranteed acceptance into this Medicare supplement plan, when you lose or terminate health coverage under certain circumstances. You may find a full list of qualifying guaranteed-issue scenarios in *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,* available at medicare.gov. If you have any question whether you qualify for guaranteed acceptance into this Medicare supplement plan, please contact us or speak with your agent.

5. HEALTH QUESTIONS

A. To the best of your knowledge and belief, do any of the following apply to you within the past **two years**? ..... ❍ Yes ❍ No

- Have you been hospitalized (more than 24 hours) three times or more, or been recommended to have inpatient surgery that hasn't yet been performed?
- Have you been hospitalized for the treatment of mental or nervous disorders, including alcohol or drug abuse?
- Have you had or been told by your physician you had a heart attack, congestive heart failure, heart valve disorder, heart rhythm disorder, enlarged heart, coronary artery disease (hardening or narrowing of the artery or arterial blockage), carotid artery disease, stroke, aneurysm, or peripheral vascular disease?
- Have you had or been told by your physician you had diabetes that requires insulin; liver disease; or broken bones due to osteoporosis?
- Have you had or received treatment for end-stage renal disease (ESRD), kidney disease, or have you received kidney dialysis?

B. To the best of your knowledge and belief, do any of the following apply to you within the past **five years**?..... ❍ Yes ❍ No

- Have you had or received treatment or surgery for cancer (except for non-melanoma skin cancer), Hodgkin's disease, melanoma, or leukemia?
- Have you had, or been recommended to have, any organ transplant other than of the cornea?

C. To the best of your knowledge and belief, have you been diagnosed by a medical professional with one or more of the following at any time? ..... ❍ Yes ❍ No

- Alzheimer's disease
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Cerebral palsy
- Cystic fibrosis
- Emphysema
- Hemophilia
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Parkinson's disease
- Rheumatoid arthritis
- Sickle cell anemia
- Systemic lupus

D. To the best of your knowledge and belief, do any of the following statements **currently** describe you?..... ❍ Yes ❍ No

- I am confined to a nursing facility
- I am hospitalized
- I am enrolled in a hospice program

STOP: If you answered yes to questions A, B, C, or D in this section, you are not eligible for this Medicare supplement plan at this time. If you need assistance answering these health questions, please contact us or speak with your agent.

If you answered no to questions A, B, C, and D in this section, please proceed to section 6.

6. YOUR CURRENT COVERAGE

A. Please review the important statements below.

- 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 policy.
- 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 the suspension.
- 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 suspension.
- 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).

B. Please answer the following questions about Medicaid coverage.

- Are you covered for medical assistance through the state Medicaid program?

NOTE TO APPLICANT: 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 you answered no, please skip to question C.
If you answered yes, please answer the following questions.

- Will Medicaid pay your premiums for this Medicare supplement policy? ..... ❍ Yes ❍ No
- Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ..... ❍ Yes ❍ No

C. Please answer the following questions about Medicare replacement coverage.

- Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, Medicare HMO or PPO)? ..... ❍ Yes ❍ No

If you answered no, please skip to question D.
If you answered yes, please answer the following questions.

- Please 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 terminate a Medicare supplement policy to enroll in the Medicare plan? ..... ❍ Yes ❍ No

D. Please answer the following questions about Medicare supplement coverage.

- Do you have another Medicare supplement policy in force? ..... ❍ Yes ❍ No

If you answered no, please skip to question E.
If you answered yes, please answer the following questions.

- With what company is your policy, and what type of plan do you have?

_____

- Do you intend to replace your current Medicare supplement policy with this policy? ..... ❍ Yes ❍ No

E. Please answer the following questions about other health insurance.

- 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 you answered no, please skip to section 7.
If you answered yes, please answer the following questions.

- With what company, and what type of policy?

_____

- Please fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END ___/___/___

7. ACCEPTANCE/AGREEMENT

By my signature below, I understand and agree that all statements and answers I've given are complete and true to the best of my knowledge, and that the policy for which I'm applying will be effective only after EPIC approves this application. Evidence of such approval will be issuance of the policy.

I understand EPIC may release information about me to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claims and as otherwise permitted by law. EPIC does not disclose protected health information in this application to entities that are not subject to the Privacy Rule unless those entities are under a Business Associate Agreement with EPIC requiring use and disclosure in accordance with the Privacy Rule.

I understand that an insurance agent or broker cannot modify or waive the terms, conditions, or provisions of the insurance policy, application or requirement imposed by EPIC, nor bind coverage or guarantee approval of coverage. I further understand that EPIC, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorneys' fees), I suffer as a result of any improper advice, action, or omission on the part of any health care provider.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that I am either listed on the SDN list or associated with an entity listed on the SDN list.

IMPORTANT FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the applicable state department of insurance.

I'm applying for a Medicare supplement policy. I've considered all factors and believe this Medicare supplement policy suits my needs. I received the Medicare supplement outline of coverage and the booklet entitled *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* before applying for this policy.

This application is not complete unless signed and dated.
IMPORTANT: Please read and sign section 8 if you are replacing a current Medicare supplement or Medicare Advantage policy with this policy.

Sign Here ➡ X

Applicant's signature _____ Date _____

8. IF YOU ARE REPLACING COVERAGE, READ AND SIGN THIS SECTION

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

The EPIC Life Insurance Company

1717 W. Broadway, Madison, WI 53713

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 coverage or Medicare Advantage plan and replace it with a policy to be issued by Wisconsin Physicians Service Insurance Corporation, underwritten by The EPIC 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 the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION, THE EPIC LIFE INSURANCE COMPANY, AGENT, BROKER, OR OTHER REPRESENTATIVE:

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 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. (Check one):

- ❍ Additional benefits
- ❍ Fewer benefits and lower premiums
- ❍ No change in benefits, but lower premiums
- ❍ Other (please specify) _____
- ❍ My plan has outpatient prescription drug coverage, and I am enrolling in Medicare Part D
- ❍ Disenrollment from a Medicare Advantage plan

  Please explain reason for disenrollment _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, pre-existing condition limitations, please skip to statement 2 below. Health conditions that 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 may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing 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.
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. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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, broker, or other representative) *Signature not required for direct response sales*

_____

(Printed name and address of issuer, agent, or broker) Agency number

Sign Here X _____ _____

Applicant's signature Date

9. PREMIUM PAYMENT OPTIONS

Please check ONE of the three options.

❑ AUTOMATIC BANK WITHDRAWAL: We electronically transfer your premium directly from your bank account at the frequency you request. When you select this option, **you save 2% on your premium**.

A. Account information

Select one: ❍ I am attaching a voided check to the bottom of this page → **Tape voided check below as shown, then skip to B.**

❍ I will provide the bank account information

Bank name _____

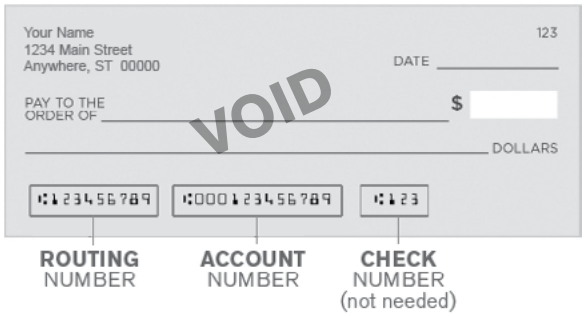
9-digit routing number_____

Account number _____

Type of account:

❍ Checking

❍ Savings (Your savings account number may be found on a bank statement or by contacting your bank)



B. Account holder information

Name _____

Address _____

City _____ State _____ ZIP code _____

C. Frequency and timing of payments

Select one: ❍ Monthly ❍ Quarterly ❍ Semiannually ❍ Annually

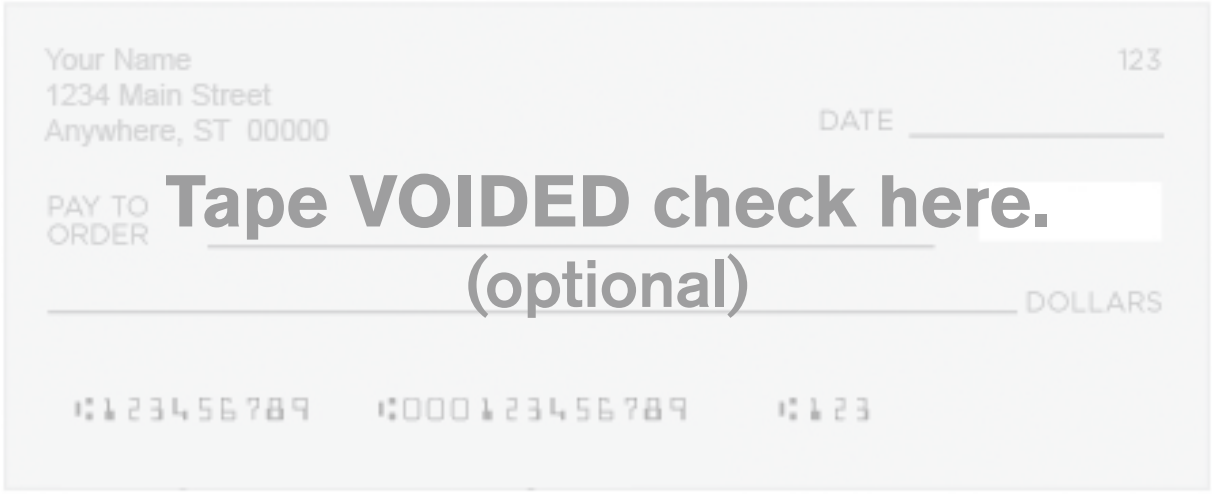
Select one: ❍ On the 20th of the month preceding coverage ❍ On the 1st of the coverage month

D. Authorization and signature

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify WPS in writing of its termination. My notification must afford WPS and my financial institution reasonable opportunity to act on it. WPS is not responsible for any loss, incorrect delivery, destruction, delay, or interception of this application and its contents by others.

Sign Here X _____ _____

Applicant's signature Date



9. PREMIUM PAYMENT OPTIONS (CONTINUED)

❑ DIRECT BILL: We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.

❑ CREDIT/DEBIT CARD: You may set up credit or debit card payments by visiting pay.wpsic.com. Please note that if you do not set up a payment within 5 business days of receipt of your application, you will automatically be enrolled in the monthly direct bill option listed above.

BILL FREQUENCY:

❍ Monthly ❍ Quarterly ❍ Semiannually ❍ Annually

Note: If you choose either of these options, you miss an opportunity to save 2% on your premium.

10. AGENCY FORM

If application is being completed through an agent, he or she must complete the following section.

A. Please list any other health insurance policies you have personally sold to the applicant that are still in force. (If none, please write none.) Also, list any policies you sold to the applicant in the past five (5) years that are no longer in force.

POLICY DESCRIPTION	IN FORCE
_____	❍ Yes ❍ No
_____	❍ Yes ❍ No
_____	❍ Yes ❍ No

B. I asked the applicant all the questions in this application, and the answers are recorded as given to me. ..... ❍ Yes ❍ No

Signed at _____ Date ____ /____/____

Writing agent (print name) _____

Signature of writing agent _____

Agency name _____

Tax ID number _____

WPS Health Insurance Medicare supplement insurance plans are underwritten by The EPIC Life Insurance Company. Neither Wisconsin Physicians Service Insurance Corporation, nor The EPIC Life Insurance Company, nor their agents are connected with the federal Medicare program. Our products are not connected with or endorsed by the United States government or the federal Medicare program. WPS and EPIC comply with applicable federal civil rights laws and do not discriminate on the basis of race, color, national origin, disability, or sex.

The EPIC Life Insurance Company
A WPS Company

1717 W. Broadway
P.O. Box 8190
Madison, WI 53708-8190

WPS HEALTH INSURANCE

Medicare Supplement Guaranteed Issue

Descriptions of Eligible Person for Guaranteed Issue (including Open Enrollment)

You are eligible for Guaranteed Issue if you meet one of the following conditions:

1. You are enrolled in an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or ceases to provide such supplemental health benefits; or you are enrolled in an employee welfare benefit plan that is primary to Medicare and the plan terminates or ceases to provide health benefits because you left the plan.

   Your guaranteed issue period begins on the later of the following: the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of a termination or cessation); or the date that the applicable coverage terminates or ceases; and ends 63 days thereafter.

2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the "Plan") under Part C of Medicare and any of the following apply; or you are 65 years of age or older and are enrolled with a Program of All-Inclusive Care for the Elderly (PACE), and there are circumstances similar to those described as follows that would permit discontinuance of your enrollment with the provider if you were enrolled in a Medicare Advantage Plan:
   (i) The organization's or Plan's certification under this part has been terminated or
   (ii) The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside, or
   (iii) You are no longer eligible to elect the Plan because of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the "Secretary"), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1851(g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1856), or the Plan is terminated for all enrollees residing within a particular residential service area; or
   (iv) You demonstrate, in accordance with guidelines established by the Secretary, that:
      (A) The organization offering the Plan substantially violated a material provision of the organization's contract with the Centers for Medicare & Medicaid Services in relation to you, including the failure to provide you, in a timely basis, with 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
      (B) The organization or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the Plan to you.
   (v) You meet such other exceptional conditions as the Secretary may provide.

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated. If you disenroll voluntarily the period begins 60 days before the effective date of disenrollment and ends 63 days after the effective date.

3. Your enrollment ceases under the same circumstances that would permit discontinuance under Section 2, and you are enrolled with one of the following:
   (i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost); or
   (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or
   (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.

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated.

4. You are enrolled in a Medicare supplement policy and the enrollment ceases because:
   (i) Of the insolvency of the issuer or bankruptcy of the non-issuer organization, or of other involuntary termination of coverage or enrollment under the policy.

   Your guaranteed issue period begins on the earlier of the following: the date that you receive notice of termination, notice of the issuer's bankruptcy or insolvency, or other such similar notice; or the date the applicable coverage is terminated; and ends on the date that is 63 days after coverage is terminated.
   (ii) The issuer of the policy substantially violated a material provision of the policy; or
   (iii) 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 you.

If you disenroll voluntarily, the period begins 60 days before the effective date of disenrollment and ends 63 days after the effective date.

5. You were enrolled under a Medicare supplement policy, and you terminate enrollment and subsequently enroll, for the first time, with (1) any Medicare Advantage organization under a Medicare Advantage Plan under Part C of Medicare, (2) any eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost), (3) any similar organization operating under demonstration project authority, (4) any PACE program under Section 1894 of the Social Security Act, or (5) a Medicare Select policy, and enrollment under this section is terminated by you during any period within the first 12 months of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated.

6. Upon first becoming enrolled for benefits under Medicare Part A and Part B, you enroll in a Medicare Advantage Plan under Part C of Medicare, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan or program within 12 months of the effective date of enrollment.

If your enrollment is terminated involuntarily, the period begins on the date that you receive notice of termination and ends 63 days after the date the coverage is terminated.

7. You enroll in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in part D, were enrolled under a Medicare supplement policy that covers outpatient prescription drugs and you terminated enrollment in the Medicare supplement policy and submit evidence of enrollment in Medicare Part D along with the application for a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, F(HD), K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued your Medicare supplement policy with outpatient prescription drug coverage.

8. Your guaranteed issue period begins on the date you receive notice from your Medicare supplement issuer during the 60-day period immediately preceding the initial part D enrollment period and ends 63 days after the date of termination.

Guaranteed issue also applies to "Open Enrollment."

There is an open enrollment period for Medicare supplement insurance plans that is a six-month period during which you may buy any Medicare supplement plan offered in your state. During this time, we must sell you a policy, even if you have health problems. The open enrollment period is a six-month period that begins on the first day of the month in which you are 65 or older and enrolled in Medicare Part B. If you are on Medicare and under age 65, you will have a six-month open enrollment period beginning the month you turn age 65. If you have any questions or would like additional information, please contact us at 1-855-937-1530.

IMPORTANT INFORMATION:
In some states, all Medicare supplement plans are offered to qualified individuals under the age of 65 and/or to Medicare-qualified individuals due to disability or end-stage renal disease. The intent of this advertisement is solicitation of insurance, and contact may be made by the insurer or a licensed agent. Neither Wisconsin Physicians Service Insurance Corporation, nor The EPIC Life Insurance Company, nor their products, nor agents are connected with, or endorsed by, the United States government or the federal Medicare program. In AR, AZ, CO, FL, IA, KS, KY, MD, MO, ND, NE, NV, OK, OR, PA, SD, TN, TX, VA, and WV, WPS Health Insurance Medicare supplement insurance plans are underwritten by The EPIC Life Insurance Company, a wholly owned subsidiary of Wisconsin Physicians Service Insurance Corporation, the plan administrator. In IL, IN, MI, NT, OH, VT, and WI, WPS Health Insurance is underwritten by Wisconsin Physicians Service Insurance Corporation. All policies have exclusions, limitations, and reductions. Benefits vary by insurance plan and the premium will vary with the amount of benefits selected. For costs and complete details of the coverage, call or write your insurance agent or the insurer.

The EPIC Life Insurance Company®
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WPS HEALTH INSURANCE
Medicare supplement insurance