ManhattanLife™
Standing By You. Since 1850.

ManhattanLife Insurance and Annuity Company
A ManhattanLife Company
Administrative Office: **P.O. Box 925568, Houston, TX 77292-5568**

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE PLAN

1. To be considered for coverage, you must have Medicare Part A and B.

2. If submitting a paper application, please complete it in ink. Be sure to sign and date this application.

PLAN SELECTION ***Check one box to apply for a Medicare Supplement insurance plan.***

☐ **Plan A** ☐ **Plan F***
☐ **Plan C*** ☐ **Plan G**
☐ **Plan D** ☐ Plan N
*** Plans C and F are only available if you are eligible for Medicare before January 1, 2020**

Requested Policy Effective Date ☐☐ Month ☐☐ Day ☐☐☐☐ Year

SPECIAL REQUESTS SECTION:

APPLICANT INFORMATION

Send Policy to: ☐ Insured ☐ Agent

Name (*First*)	(*Middle)*	(Last)		
Home Address (No P.O. Boxes)		City	State	Zip Code
Correspondence/Billing Address (If different than home address)		City	State	Zip Code
Primary Phone No. ( )	Secondary Phone No. ( )	Age	Date of Birth (Month/Day/Year)	
Gender ☐ Male ☐ Female	Social Security Number (SSN)	Email Address		

MEDICARE BENEFICIARY IDENTIFIER NO. (MBI) _____
(This number must be provided to us to complete your application process)

Medicare Part A Effective Date: Medicare Part B Effective Date:

If you are not covered under Medicare Part A, what is your eligibility date: _____

If you are not covered under Medicare Part B, indicate the date you plan to enroll: _____

Are You Applying for Household Discount? ☐ Yes ☐ No

If "**Yes**," does your household resident have an existing Medicare supplement policy with ManhattanLife Insurance and Annuity Company, Western United Life Assurance Company, Family Life Insurance Company, or The Manhattan Life Insurance Company? ☐ Yes ☐ No

Are you married and residing with your spouse or Civil Union/Domestic Partner, or have you been residing, for at least the past 12 months, with someone who is at least 50 years old? ☐ Yes ☐ No

Household Resident Information

Name (*First*)	(*Middle)*	(*Last*)
Resident's Date of Birth (Month/Day/Year)	Resident's SSN	

SELECT YOUR PREMIUM PERIOD ***(choose one)*** This is the frequency in which you want to pay your premiums.

☐ **Premium to be billed by mail (Direct Billing)** (not available for monthly billing)

I will pay my premium: ☐ **Bank Draft (EFT)** ☐ **Monthly** ☐ **Quarterly** ☐ **Semi-Annually** ☐ **Annually**

PREMIUM PAYMENT OPTIONS – Total amount you are submitting for the Premium Period selected from above.

Monthly Premium Rate	**$**		
Quarterly Billing Rate	$		(Monthly Billing Rate multiplied by 3)
Semi-Annual Billing Rate	$		(Monthly Billing Rate multiplied by 6)
Annual Billing Rate	$		(Monthly Billing Rate multiplied by 12)
Household Discount	$		
Policy Fee	$	25.00	
TOTAL PREMIUM	**$**		

If paying by check, please make your checks payable to ***ManhattanLife Insurance and Annuity Company***.

ELIGIBILITY QUESTIONS

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

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

b) If "Yes," what is the effective date?

2. Are you applying during guarantee issue period? ☐ Yes ☐ No

3. 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 this question and proceed to Question 4.

If "Yes,"

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

4. a) Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ Yes ☐ No

If "Yes," fill in your start and end dates.

START DATE: ____/____/____ END DATE: ____/____/____

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

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

d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No

5. a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

b) If "Yes," with which Company: _____

with which plan: _____

and what paid-to-date do you have? _____

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

6. Have you had any other health insurance coverage within the past 63 days (for example, an employer welfare benefit plan, union, or individual plan)? ☐ Yes ☐ No

a) If "**Yes**," was the plan primary or secondary to Medicare? _____

b) Please list the plan name and reason for termination. _____

c) Please list the plan dates of coverage.

START DATE: ____/____/____ END DATE: ____/____/____

d) Do you intend to replace the above-mentioned plan with this policy? ☐ Yes ☐ No

STATEMENT OF HEALTH QUESTIONS **(Please answer the following questions to the best of your knowledge.)**
You are not required to answer the following health questions if you are in open enrollment or a guaranteed issue period.

1.	UNDERWRITING RISK CLASSIFICATION QUESTION: Have you used any form of tobacco, an electronic cigarette (e-cig), or other nicotine products in the past 12 months?	☐ Yes	☐ No
2.	Within the last 12 months, have you had a seizure?	☐ Yes	☐ No
3.	Are you bedridden, confined to a wheelchair, or require the assistance of a motorized mobility device?	☐ Yes	☐ No
4.	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 for the same or similar condition?	☐ Yes	☐ No
5.	Are you currently using the services of a home healthcare agency?	☐ Yes	☐ No
6.	Have you been advised by a physician to have treatment, follow-up visits, further diagnostic evaluation, diagnostic testing or therapy?	☐ Yes	☐ No
7.	Is surgery, including cataracts, anticipated in the next twelve months?	☐ Yes	☐ No
8.	At any time, have you been medically diagnosed with, treated for, or had any surgery for any of the following?		
	a. Parkinson's disease, dementia, Alzheimer's disease, multiple or amyotrophic lateral sclerosis (Lou Gehrig's disease), Huntington's disease, or cerebral palsy?	☐ Yes	☐ No
	b. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection?	☐ Yes	☐ No
	c. Diabetes that has required more than 50 units of insulin daily, or more than 2 oral medications?	☐ Yes	☐ No
	d. Chronic kidney disease, kidney failure, or kidney disease requiring dialysis?	☐ Yes	☐ No
	e. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary condition, or any other cardio-pulmonary disorder requiring oxygen?	☐ Yes	☐ No
	f. Systemic lupus, scleroderma, or myasthenia gravis?	☐ Yes	☐ No
9.	Do you have an implanted cardiac defibrillator?	☐ Yes	☐ No
10.	Have you had or been advised to have an organ or stem cell transplant (excluding cornea implants)?	☐ Yes	☐ No
11.	Within the past two years, have you been medically diagnosed with, treated for, or had surgery for:		
	a. Osteoporosis with fractures?	☐ Yes	☐ No
	b. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have a joint replacement?	☐ Yes	☐ No
12.	Within the past two years, have you been medically diagnosed with, treated for, or had surgery for any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder?	☐ Yes	☐ No
13.	Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
	a. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery, or stent replacement?	☐ Yes	☐ No
	b. Atrial fibrillation, any heart or heart valve disorder or implantation of a pacemaker?	☐ Yes	☐ No
	c. A stroke or transient ischemic attack (TIA)?	☐ Yes	☐ No
14.	Within the past five years, have you been treated for, or been advised by a physician to have treatment for cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease?	☐ Yes	☐ No
15.	Within the past 3 years, have you been treated for, or been advised by a physician to have treatment for any mental or nervous disorder requiring treatment (including hospital confinement) by a psychiatrist, psychologist, counselor, or therapist?	☐ Yes	☐ No
16.	Within the past two years, have you been treated for, or been advised by a physician to have treatment for Alcoholism or drug abuse?	☐ Yes	☐ No
17.	Within the past 3 years, have you been treated for, or been advised by a physician to have treatment for internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma?	☐ Yes	☐ No

STATEMENT OF HEALTH QUESTIONS (CONTINUED)

18. Within the past 3 years, have you been medically diagnosed with, treated for, or had surgery for chronic hepatitis or cirrhosis? ☐ Yes ☐ No

19. Are you currently being treated for, been diagnosed with or do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease? ☐ Yes ☐ No

20. Do you have diabetes with high blood pressure? If "Yes," have you: ☐ Yes ☐ No

a. Taken more than two medications for either condition (insulin dependent or oral medications?) ☐ Yes ☐ No

b. Had any changes in your medications within the last two years? ☐ Yes ☐ No

21. **HEIGHT: Feet:** _____ **Inches** _____ **WEIGHT: Pounds** _____

22. Have you taken any prescription medications within the last 24 months? If "Yes," please list all medication(s) you have taken or are currently taking. Attach an additional sheet if necessary. *Please **DO NOT** list water pill, water retention, fluid retention or blood thinner as these are not medical conditions and will require a telephone interview. (Attach an additional sheet if necessary.) ☐ Yes ☐ No

Prescribed Medication	Date Prescribed	Frequency and Dosage	*Diagnosis/Onset Date

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT.

1. You do not need more than one Medicare Supplement Insurance Policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
4. If, after purchasing this policy, you become eligible for Medicaid, 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 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 suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

Initials of Proposed Insured: _____ Date: _____

OPEN ENROLLEMENT INFORMATION

Underage Coverage: Plans C and D are available for qualified consumers aged 50–64 who are eligible for Medicare by reason of disability.

Open Enrollment: You are eligible for Guaranteed Acceptance in Plan C if your Medicare Part B effective date is prior to January 1, 2020, and you apply:

- within six months of enrollment in Medicare Part B; or,
- within six months beginning with the month in which a retroactive determination of eligibility for Medicare is made.

You are eligible for Guaranteed Acceptance in Plan D if:

- your Medicare Part B effective date is prior to January 1, 2020, and you apply within six months of enrollment in Medicare Part B and you are not covered by any other Medicare Supplement Plan; or,
- your Medicare Part B effective date is on or after January 1, 2020, and you apply within 12 months of enrollment in Medicare Part B.

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc. (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give to ManhattanLife Insurance and Annuity Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing ManhattanLife Insurance and Annuity Company to receive my health information, prescription drug usage history and my non-medical information. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by ManhattanLife Insurance and Annuity Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for the evaluation and the underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with ManhattanLife Insurance and Annuity Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to ManhattanLife Insurance and Annuity Company will result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying ManhattanLife Insurance and Annuity Company in writing at their Medicare Supplement Administrative Office: P.O. Box 925568, Houston, Texas 77292-5568. I understand that such revocation will not have any effect on actions ManhattanLife Insurance and Annuity Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

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 unless and until the application has been accepted and approved by the Company, the full 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 unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him/her, the completed application and that he/she 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.

WARNING: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed At: _____ Dated: _____
(City/State) (Month/Day/Year)

Applicant's (or Authorized Representative's) Signature: _____

AUTHORIZATION - ELECTRONIC FUNDS TRANSFER (EFT)

IN FAVOR OF: **ManhattanLife Insurance and Annuity Company**
Administrative Office: **P.O. Box 925568, Houston, TX 77292-5568**

Name of Bank Customer: _____

Insured's Name: _____

Account Number: _____

Routing Number: _____

Requested Draft Date:

(Must be 1st-28th only)

☐ **Checking**

☐ **Savings**

To (Name of Bank): _____

Address of Bank: _____

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by ManhattanLife Insurance and Annuity Company (Company), on my account by and payable to the order of the Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by the Company shall be the same as if it were a check drawn on 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 or other orders drawn by the Company. I further agree that if any such checks or other orders drawn by the Company be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor may result in forfeiture of insurance subject to the policy's grace period.

_____ _____

Date **Signature of Depositor**

I am aware that if my application is approved, my initial premium will be drafted upon approval.

To: The Bank above

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor may result in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

AUTHORITY TO HONOR PREMIUM CHECKS

AGENT'S CERTIFICATION – To be completed by the agent (Attach separate sheet, if necessary)

1. List any other health insurance policies or coverages sold to the Applicant which are still in force.

2. List any other health insurance policies or coverages sold to the Applicant in the past five (5) years which are no longer in force.

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and,

2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agency Name: _____

_____ _____

Signature of Agent **Printed Agent's Name**

_____ _____ _____ _____ _____

Agent Phone No. **Agent No.** **% Credit** **%** **State**

Agency Name: _____

_____ _____

Signature of Agent **Printed Agent's Name**

_____ _____ _____ _____ _____

Agent Phone No. **Agent No.** **% Credit** **%** **State**

EMAIL CONSENT AUTHORIZATION

☐ I give my written consent to allow ManhattanLife Insurance and Annuity Company (Company) to communicate with me by email to the address(es) listed below. I confirm that I have authorization to provide consent for email to the email address(es) that I provide below and further agree to indemnify and hold harmless the Company for any action or loss arising from any incorrect or false email address(es) provided below. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation.

☐ I decline to give consent to the Company to communicate with me by email. (Do not provide email address below).

_____

Email Address

☐ Check *only* if the email address is the same as the email address that is provided on page 1

_____ _____

Signature **Date**

Note: The applicant electing to allow for notices and communications to be sent to the electronic mail address provided by the policyholder should be aware that the insurer rightfully considers this election to be consent by the applicant that all notices may be sent electronically, including notice of non-renewal and notice of cancellation. Therefore, the applicant should be diligent in updating the electronic mail address provided to the insurer in the event that the address should change.