Medicare Supplement Underwriting Guide

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INTRODUCTION

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare Supplement insurance policies for LifeShield. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. To ensure we accomplish this goal, the agent or applicant will be contacted directly by underwriting if there are any issues with an application.

CONTACTS

Addresses for Mailing New Business and Delivery Receipts

Mailing Address Overnight/Express Address

LifeShield Administrative Office
5500 N Western Ave, Ste 200
Oklahoma City, OK 73118

Policyowner Services
PO Box 14574
Oklahoma City, OK 73113-0574

Premium Payment Address

LifeShield
PO Box 14574
Oklahoma City, OK 73113-0574

You can access your book of business, general and state specific forms along with online forms on your Agent portal at: www.lsnagentsportal.com

Important Phone & Fax Numbers

Area	Phone Numbers
Policyowner Service	844-649-1897
Policyowner Service **Fax**	405-285-4959
New Business/Underwriting	844-649-1898
New Business/Underwriting **Fax**	385-207-7882
Agent Services	833-808-0245
Claims	844-649-1897

MACRA

Plan Changes under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") – Effective January 1, 2020

MACRA – Medicare Access and CHIP Reauthorization Act of 2015 – is the largest scale change to the American health care system following the Affordable Care Act in 2010.

Starting January 1, 2020, Medigap plans sold to new people with Medicare will not be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to individuals new to Medicare starting on January 1, 2020. If a person already has either of these 2 plans or the high deductible version of Plan F or are covered by one of these plans before January 1, 2020, he/she will be able to keep that plan. If a person is eligible for Medicare before January 1, 2020, but not yet enrolled, he/she may still be able to buy one of these plans.

This means that agents need to verify when the individual client became Medicare eligible:

- Individuals born on December 31, 1954 or before - become eligible for Medicare before January 1, 2020 - and have a right to purchase a Medicare Supplement Plan C or Plan F.

- Individuals born on January 1, 1955 or after - become eligible for Medicare on or after January 1, 2020 - and cannot purchase a Medicare Supplement Plan C or Plan F.

Only applicants **first** eligible for Medicare prior to 2020 may obtain Plans C, F, and high deductible F.

POLICY ISSUE GUIDELINES

All applicants must be covered under Medicare Part A & B. Policy issue is state specific. The applicant's state of residence controls the application, forms, premium and policy issued. If an applicant has more than one residence, the state where taxes are filed should be considered as the state of residence. Please refer to your introductory materials for required forms specific to your state.

- **Clients who are first eligible for Medicare on or after January 1, 2020 or first become eligible for Medicare due to age, disability, or end-stage renal disease, on or after Jan. 1, 2020 are considered "Newly Eligible".**
- **Clients who were first eligible for Medicare prior to January 1, 2020 are considered "Not Newly Eligible".**

Open Enrollment

To be eligible for open enrollment, an applicant must be at least 64 ½ years of age (in most states) and be within six months of his/her enrollment in Medicare Part B.

If an individual is entitled to a OE/GI situation we must honor the processing of that application in that method. For compliance purposes we are unable to medically underwrite an individual who is eligible for an Open Enrollment or Guarantee Issue right outlined by CMS.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month open enrollment period **upon reaching age 65**.

> ***Note: Applications for clients under the age of 65 must include a copy of their Medicare ID Card with the application.***

Anniversary and Birthday Rules

Residents in the following states have additional Open Enrollment/Guaranteed Issue periods:

Missouri anniversary rule:
Missouri provides a Guaranteed Issue period for individuals currently enrolled in Medicare Supplement plans.

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior and ending 30 days after the applicant's policy anniversary date.
- The applicant must choose the same Medicare Supplement plan they currently have (F to F, G to G).
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule page.

Illinois birthday rule:
This birthday rule only applies to individuals between the ages of 65 through 75 who are currently enrolled in Medicare Supplement plans. During this period, they can enroll in a plan from their current carrier (LifeShield).

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior to and ending 45 days after the applicant's birthday.
- Effective date must fall on birthday or up to 90 days after birthday.
- Their new plan's benefit level must not exceed that of their current plan.

Kentucky birthday rule:

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior to and ending 60 days after the applicant's birthday.
- Effective date must fall on the applicant's birthday or up to 90 days after birthday.
- The applicant must choose the same Medicare Supplement plan they currently have (F to F, G to G).
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates such as an ID card or Schedule page.

Louisiana birthday rule:
Applicants can enroll in a plan from their current carrier (LifeShield).

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior and ending 63 days after the applicant's birthday.
- Effective date must fall on birthday or up to 90 days after birthday.
- Their new plan's benefit level must not exceed that of their current plan.

Maryland birthday rule:

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior to and ending 30 days after the applicant's birthday.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to the current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule page.

Nevada birthday rule:

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior to the first day of the applicant's birthday month and ending 60 days after the applicant's birthday.
- Effective date must fall on the first day of the applicant's birthday month or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to the current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule page.

Oklahoma birthday rule:

Oklahoma provides a Guaranteed Issue period for applicants currently enrolled in a Medicare Supplement plan.

- Application must be signed (application signature date) within the enrollment period beginning 30 days prior to and ending 60 days after the applicant's birthday.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to the current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule page.

States with Under Age 65 Requirements

Arkansas – Plan A is available. Open enrollment if applied for within six months of Part B enrollment.

Colorado – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Delaware – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Florida – All plans are available. Open enrollment if applied for within six months of Part B enrollment or within the first two months after termination of group health coverage.

Georgia – All Plans offered are available. Open enrollment if applied for within six months of Part B enrollment.

Illinois – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Indiana – Plan A is available. Open enrollment if applied for within six months of Part B enrollment.

Kansas – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Kentucky – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Louisiana – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Maryland – Plan A is available. Open enrollment if applied for within six months of Part B enrollment.

Missouri – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Mississippi – All plans available. Open enrollment if applied for within six months of Part B enrollment.

New Jersey – Newly eligible beneficiaries receive Open Enrollment if applied for within twelve months of Part B enrollment. Individuals who are entitled to Medicare benefits due to disability prior to 1/1/20 that are still within 6 months of enrolling in part B and not currently covered by any other Medicare Supplement plan will have the option of purchasing plans C and D. Available only to ages 50 – 64.

States with Under Age 65 Requirements (continued)

North Carolina – Plans A & F & G are available. Open enrollment if applied for within six months of Part B enrollment.

Oklahoma – Plan A is available. Open enrollment if applied for within six months of Part B enrollment.

Pennsylvania – All plans available. Available only to ages 50 – 64.

South Dakota – All plans available. Open enrollment if applied for within six months of Part B enrollment.

Tennessee – All plans available. Open enrollment if applied for within six months of Part B enrollment for persons no longer having access to alternative forms of health insurance coverage due to termination or action unrelated to the individual's status, conduct or failure to pay premium or persons being involuntarily dis-enrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of Social Security Act. Alternative forms of health insurance in the statement above include accident and sickness policies, employer sponsored group health coverage or Medicare Advantage plans.

Texas – Plan A is available. Open enrollment if applied for within six months of Part B enrollment.

Virginia – Plan A is available. Open enrollment if applied for within six months of Part B enrollment.

Selective Issue

Applicants over the age of 65 and at least six months beyond enrollment in Medicare Part B will be selectively underwritten, except in CT, which is a year-round open enrollment state. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any health questions are answered "Yes," the applicant is not eligible for coverage. Applicants will be accepted or declined. Elimination endorsements will not be used.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Coverage will be declined for those applicants who are outside the established height and weight guidelines. Health information, including answers to health questions on applications and claims information, is confidential and is protected by state and federal privacy laws. Accordingly, LifeShield does not disclose health information to any non-affiliated insurance company.

Application Dates

OPEN ENROLLMENT – Up to 6 months prior to the month the applicant turns 65.

Missouri – Applications may be taken up to 60 days prior to the requested coverage effective date.

UNDERWRITTEN – Up to 60 days prior to the requested coverage effective date.

GROUP HEALTH – Individuals whose employer group health plan coverage is ending can apply up to three months prior to the requested effective date of coverage.

Coverage Effective Dates

Coverage will be made effective as indicated below:

1. Between age 64 ½ and 65 – The first of the month the individual turns age 65.
2. All Others – Application date or up to 60 days from the application date or if replacing coverage, the date of termination of other coverage.

Reinstatements

When a Medicare Supplement policy has lapsed and it is ***within 90 days of the last paid to date***, coverage may be reinstated, based upon meeting the underwriting requirements. Policies reinstated will have a gap in coverage (from paid to date to date of reinstatement). Upon reinstatement renewal commission rates will continue based on the policy's duration.

When a Medicare Supplement policy has lapsed and it is ***more than 90 days beyond the last paid to date***, the coverage cannot be reinstated. The client may, however, apply for new coverage. All underwriting requirements must be met before a new policy can be issued.

Replacements

A "replacement" takes place when an applicant terminates an existing Medicare Supplement policy or Medicare Advantage policy and replaces it with a new Medicare Supplement policy. LifeShield requires a fully completed application when applying for a replacement policy (both internal and external replacements) and replacement form.

If an applicant has a Medicare Supplement policy issued by LifeShield within the last 60 days, any new applications will be considered a replacement application. All replacements involving a Medicare Supplement, Medicare Select or Medicare Advantage plan must include a completed Replacement Notice. One copy is left with the applicant; one copy should accompany the application. Internal replacements are not allowed for the exact same coverage. The replacement Medicare Supplement policy cannot be issued in addition to any other existing Medicare Supplement, Medicare Select or Medicare Advantage plan.

A policy owner wanting to apply from a tobacco to a non-tobacco plan must complete a new application plus other required forms and qualify for coverage.

Telephone Interviews

The underwriting department may call your applicant to verify personal and health information on underwritten cases. Please advise your client that they may receive a call during the underwriting process. Your applicant should be ready to answer any personal and health information related to their application including medications. Applications requiring a telephone interview will be declined if we are unable to complete an interview.

Pharmaceutical Information

LifeShield has implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. To obtain the pharmaceutical information as requested, a completed Health Information Authorization (HIPAA required authorization) form must be completed with all underwritten applications. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This collected information will be used to accept or decline coverage.

Policy Delivery Receipt

Policy delivery receipts are required on all policies issued in Nebraska, if the policy is not delivered by mail.

Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the client. The second copy must be returned to LifeShield in the postage-paid envelope once the policy has been delivered.

Guaranteed Issue Rules

The situations listed below are based upon scenarios found in the Guide to Health Insurance.

Note: Not all plans offered are available as guaranteed issue. Plans C, F (including High Deductible F) are not available to newly eligible Medicare beneficiaries. Plan selection is subject to availability in any particular state.

Client can/must apply for a Medigap policy…
No later than 63 calendar days after the latest of these 3 dates:
1. Date the coverage ends.
2. Date on the notice the client gets, telling him/her that coverage is ending (the client receives one)
3. Date on a claim denial, if this is the only way the client knows that his/her coverage ended
As early as 60 calendar days before the date the client's Medicare SELECT coverage will end, but no later than 63 days after the client's Medicare SELECT coverage ends
No later than 63 calendar days from the date the client's coverage ends.

Note: *Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.

Guaranteed Issue Situation	**Client has the right to buy…**
Client is in the original Medicare Plan and has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. The coverage is ending. **Note:** In this situation, state laws may vary.	Medigap Plan A, B, C*, D*, F*, High Deductible F, G*, High Deductible G, K or L that is sold in client's state by any insurance company. Plan selection is subject to availability. If the client has COBRA coverage, client can either buy a Medigap policy right away or wait until the COBRA coverage ends. Plan selection is subject to availability.
Client is in the original Medicare Plan and has a Medicare SELECT policy. Client moves out of the Medicare SELECT plan's service area. Client can keep the Medigap policy or he/she may want to switch to another Medigap policy.	Medigap Plan A, B, C*, D*, F*, High Deductible F, G*, High Deductible G, K or L that is sold in client's state by any insurance company. Plan selection is subject to availability.
Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy coverage otherwise ends through no fault of client.	Medigap Plan A, B, C*, D*, F*, High Deductible F, G*, High Deductible G, K or L that is sold in client's state by any insurance company. Plan selection is subject to availability.

* People eligible for Medicare **on or after** January 1, 2020 have the right to buy Plan D instead of C and Plan G (if available from the company). If you were eligible for Medicare **before January 1, 2020** but not enrolled, you may be able to buy Plan C or F (including High Deductible F).

Group Health Plan Proof of Termination

Proof of Involuntary Termination

If applying for Medicare Supplement, Underwriting cannot issue coverage as Guaranteed Issue without proof that an individual's employer coverage is no longer offered. The following is required:

- Complete the Medicare and Insurance Information section on the Medicare Supplement application; and
- Provide a copy of the termination letter, showing date of and reason for termination, from the employer or group carrier.

Proof of Voluntary Termination

Under the state specific voluntary terminations scenarios, the following proof of termination is required along with completing the Medicare and Insurance Information section on the Medicare Supplement application:

- Policy of Group Health Plan Coverage
- In IA, NM, OK provide proof of change in benefits from employer or group carrier

Guaranteed Issue Rights for Voluntary Termination of Group Health Plan

State	Qualifies for Guaranteed Issue...
CO, IL, IN, NJ, OH, TX	If the employer sponsored plan is primary to Medicare.
FL, KS, MO	No conditions – always qualifies.
IA	If the employer sponsored plan's benefits are reduced but does not include a defined threshold.
NM, OK	If the employer sponsored plan's benefits are reduced substantially.

For purposes of determining GI eligibility due to a Voluntary Termination of an employer sponsored group welfare plan, a reduction in benefits will be defined as any increase in the insured's deductible amount or their coinsurance requirements (flat dollar co-pays or coinsurance percentage). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for GI eligibility. This definition will be used to satisfy IA, NM, OK requirements. Proof of coverage termination is required.

Additional State Specific Guaranteed Issue Rights:

Connecticut – All plans available for all Guaranteed Issue situations.

Minnesota - Basic Plan and any combination of these riders: Part A Deductible, Part B Deductible, and Part B Excess for all guaranteed issue situations. Note: The Part B deductible rider and Extended Plan are not available for newly eligible beneficiaries.

Guaranteed Issue Rights for Loss of Medicaid Qualification

State	Guaranteed Issue Situation	Client has the right to buy…
CO	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending six months after the termination date.	Medigap Plan A, B, C*, D*, F*, High Deductible F, G*, High Deductible G, K or L offered by any issuer;
KS	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Any Medigap plan offered by any issuer.
TN	Client, **age 65 and older** covered under Medicare Part B, enrolled in Medicaid (TennCare) and the enrollment involuntarily ceases, is in a Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date. Client, **under age 65**, losing Medicaid (TennCare) coverage have a six-month Open Enrollment period beginning on the date of involuntary loss of coverage.	Medigap Plan A, B, C*, D*, F*, High Deductible F, G*, High Deductible G, K or L offered by any issuer. Any Medigap plan offered by any issuer
TX	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Medigap Plan A, B, C*, D*, F*, High Deductible F, G*, High Deductible G, K or L offered by any issuer; except for persons under 65 years of age, only Plan A is available.

Note: *Plans C and F are not available to newly eligible Medicare beneficiaries.
**Plans D and G are only available to newly eligible Medicare beneficiaries

MEDICARE ADVANTAGE (MA)

Medicare Advantage (MA) Annual Election Period

General Election Periods for Medicare Advantage (MA)	Timeframe	Allows for…
Annual Election Period (AEP)	Oct. 15th – Dec. 7th each year	• Enrollment selection for a MA plan • Disenrollment from a current MA plan • Enrollment selection for Medicare Part D
Medicare Advantage Open Enrollment Period (MA OEP)	Jan. 1st – March 31st of every year	• MA enrollees to disenroll from any MA plan and return to Original Medicare • Switch from one Medicare Advantage plan to another The MA OEP **does not** provide an opportunity to: • Switch from original Medicare to a Medicare Advantage Plan • Switch from one Medicare Prescription Drug Plan to another • Join, switch, or drop a Medicare Savings Account Plan

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local State Health Insurance Assistance Program (SHIP) office for direction.

Medicare Advantage (MA) Proof of Disenrollment

If applying for a Medicare Supplement, **Underwriting cannot issue coverage without proof of disenrollment.** If a member disenrolls from Medicare, the MA plan must notify the member of his/her Medicare Supplement Guaranteed Issue rights.

Disenroll during AEP and MA OEP

- Complete the Medicare and Insurance Information section of the application; and
- Send a copy of the applicant's MA plan's disenrollment or termination notice

If an individual is disenrolling outside AEP/MA OEP

- Complete the Medicare and Insurance Information section of the application; and
- Send a copy of the applicant's MA plan's disenrollment or termination notice with the application

For any questions regarding MA disenrollment eligibility, contact your State Health Insurance Assistance Program (SHIP) office or call 1-800-MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

Guaranteed Issue Rights

The situations listed below are based upon scenarios found in the Guide to Health Insurance.

Note: All plans are not Guaranteed Issue. Plans C and F (including High Deductible F) are not available to newly eligible Medicare beneficiaries. "Newly eligible" is defined as individuals who have attained age 65 on or after Jan. 1, 2020 or first become eligible for Medicare due to age, disability, or end-stage renal disease, on or after Jan. 1, 2020. While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, only for newly eligible beneficiaries where offered

Guaranteed Issue Situation	Client has the right to…	Client can/must apply for a Medigap policy…
Client's MA plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the plan's service area.	Buy a Medigap Plan A, B, C*, D**. G**, F*, K or L that is sold in the client's state by any insurance carrier. Client must switch to original Medicare Plan.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
(Trial Right) Client joined an MA plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to original Medicare.	Buy any Medigap plan that is sold in your state by any insurance company.	As early as 60 calendar days before the date the client's coverage will end, but no later than 63 calendar days after his/her coverage ends. **Note:** The client's rights may last for an extra 12 months under certain circumstances.

Note: *Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.

Guaranteed Issue Rights (continued)

Guaranteed Issue Situation	Client has the right to…	Client can/must apply for a Medigap policy…
(Trial Right) Client dropped his/her Medigap policy to join an MA Plan for the first time, has been in the plan less than a year and want to switch back to original Medicare.	Obtain client's Medigap policy back if that carrier still sells it. If his/her former Medigap policy is not available, the client can buy a Medigap Plan A, B, C*, D**. G**, F*, K or L that is sold in his/her state by any insurance carrier.	As early as 60 calendar days before the date the client's coverage will end, but no later than 63 calendar days after his/her coverage ends. **Note:** The client's rights may last for an extra 12 months under certain circumstances.
Client leaves a MA plan because the company has not followed the rules or has misled the client.	Buy Medigap plan A, B, C*, D**, G**, F*, K or L that is sold in the client's state by any insurance company.	No later than 63 calendar days from the date the client's coverage ends.

Note: *Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.

PREMIUM

Utilize the Outline of Coverage

Determine ZIP code where the client resides and find the rate page in the outline of coverage

- Determine Plan
- Determine if non-tobacco or tobacco
- Find Age/Gender – The age is based on the application date
- Apply the household discount, if applicable.
- This will be your base premium (do not forget the policy fee, if applicable)

Note: If a premium is paid by a business account, refer to the "Business Checks" section of this guide to determine if acceptable.

Tobacco rates

Tobacco rates DO NOT apply during Open Enrollment or Guaranteed Issue in the following states:

- AR, CO, FL, IA, KY, LA, MD, MO, NC, ND, NJ, NM, OH, PA, TN, VA

Household Discount

If an applicant resides with at least one, but no more than three other adults a 7% household discount is available. (FL applications receive a 3.5% discount) See the chart below for details regarding discount availability by state. Refer to the premium calculation sheet included in the application packet for assistance.

State	Description:
All states not indicated below	HHD Rule 1: • Individuals who live with their spouse, including validly recognized civil union and domestic partners; or • Individuals that currently have a household resident (at least one, no more than three) with whom they have continuously resided for the last 12 months.
OH, OK, ND, NJ	HHD Rule 2: • Individuals who live with their spouse, including validly recognized civil union and domestic partners, who owns or is issued a Medicare Supplement policy with us; or • Individuals that currently have a household resident (at least one, no more than three) with whom they have continuously resided for the last 12 months and at least one owns or is issued a Medicare Supplement with us.
FL	HHD Rule 3: • Individuals that currently have a household resident (at least one, no more than three) who holds or is applying for a Medicare Supplement for us.

Types of Medicare Policy Ratings

COMMUNITY RATED

The same monthly premium is charged to everyone who has the Medicare policy, regardless of age. Premiums are the same no matter the age of the applicant. Premiums may go up because of inflation and other factors, but not based on age.

ISSUE AGE RATED

The premium is based on the age the applicant is when the Medicare policy is bought. Premiums are lower for applicants who buy at a younger age and will not change as their age increases. Premiums may go up because of inflation and other factors, but not because of applicant's age.

ATTAINED AGE RATED

The premium is based on the applicant's current age so the premium goes up as the applicant's age increases. Premiums are low for younger buyers but go up as their age increases. In addition to change in age, premiums may also go up because of inflation and other factors.

Rate Type Available by State

State	Tobacco/ Non-Tobacco Rates	Gender Rates	Attained Age, Issue Age, or Community Rated	Tobacco Rates During OE	Policy Fee	Household Discount
AL	Y	Y	A	Y	Y	Y
AR	Y	N	C	N	N	Y
AZ	Y	Y	I	Y	Y	Y
CO	Y	Y	A	N	Y	Y
DC	Y	Y	A	Y	Y	Y
DE	Y	Y	A	Y	Y	Y
FL	Y	Y	I	N	Y	Y (3.5%)
GA	Y	Y	I	Y	Y	Y
IA	Y	Y	A	N	Y	Y
IL	Y	Y	A	Y	Y	Y
IN	Y	Y	A	Y	Y	Y
KS	Y	Y	A	Y	Y	Y
KY	Y	Y	A	N	Y	Y
LA	Y	Y	A	N	Y	Y
MD	Y	Y	A	N	Y	Y
MO	Y	Y	I	N	Y	Y
MS	Y	Y	A	Y	Y ($6.00)	Y
NC	Y	Y	A	N	Y	Y
ND	Y	Y	A	N	Y	Y
NE	Y	Y	A	Y	Y	Y
NJ	Y	Y	A	N	Y	Y
NM	Y	Y	A	N	Y	Y
NV	Y	Y	A	Y	Y	Y
OH	Y	Y	A	N	Y	Y
OK	Y	Y	A	Y	Y	Y
PA	Y	Y	A	N	Y	Y
SC	Y	Y	A	Y	Y	Y
SD	Y	Y	A	Y	Y	Y
TN	Y	Y	A	N	Y	Y
TX	Y	Y	A	Y	Y	Y
UT	Y	Y	A	Y	Y	Y
VA	Y	Y	A	N	Y	Y
WV	Y	Y	A	Y	N	Y
WY	Y	Y	A	Y	Y	Y

Height and Weight Chart

Eligibility

To determine whether your client may qualify for coverage, locate their height and weight in the chart below. If the weight is in the Decline column, the applicant is not eligible for coverage.

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4’2”	< 54	54-145	146>
4’3”	< 56	56-151	152>
4’4”	< 58	58-157	158>
4’5”	< 60	60-163	164>
4’6”	< 63	63-170	171>
4’7”	< 65	65-176	177>
4’8”	< 67	67-182	183>
4’9”	< 70	70-189	190>
4’10”	< 72	72-196	197>
4’11”	< 75	75-202	203>
5’0”	< 77	77-209	210>
5’1”	< 80	80-216	217>
5’2”	< 83	83-224	225>
5’3”	< 85	85-231	232>
5’4”	< 88	88-238	239>
5’5”	< 91	91-246	247>
5’6”	< 93	93-254	255>
5’7”	< 96	96-264	262>
5’8”	< 99	99-269	270>
5’9”	< 102	102-277	278>
5’10”	< 105	105-285	286>
5’11”	< 108	108-293	294>
6’0”	< 111	111-302	303>
6’1”	< 114	114-310	311>
6’2”	<117	117-319	320>
6’3”	< 121	121-328	329>
6’4”	< 124	124-336	337>
6’5”	< 127	127-345	346>
6’6”	< 130	130-354	355>
6’7”	< 134	134-363	364>
6’8”	< 137	137-373	374>
6’9”	< 140	140-382	383>
6’10”	< 144	144-392	393>
6’11”	< 147	147-401	402>
7’0”	< 151	151-411	412>
7’1”	< 155	155-421	422>
7’2”	< 158	158-431	432>
7’3”	< 162	162-441	442>
7’4”	< 166	166-451	452>

Policy Fee

There will be a one-time policy fee of $25.00 (fee is $6.00 in MS) that will be collected with each applicant's initial payment. The policy fee is not commissionable.

Collection of Premium

Premiums are calculated based upon the applicant's exact age at the time of application, not their age as of the requested coverage effective date.

- At least one month's premium must be submitted with the application. If a mode other than monthly EFT is selected, the full modal premium must be submitted with the application.
- Acceptable forms of payments include EFT, money orders, cashier's checks, counter checks, and personal checks. ***Third-party checks will NOT be accepted, and Third-party payors cannot obtain a money order or cashier's check on behalf of the applicant.***
  NOTE: LifeShield does not accept post-dated checks or payments from any Third Parties, as premium for Medicare Supplement.
- EFT is the only allowable form of payment for the E-application process. A paper application should be used if applicant is paying with direct bill.
- **Direct Monthly is not an available payment option.**
- **The applicant has the option of paying their premium by their Social Security Schedule as selected on the application.**
- For monthly Bank Draft, the "Bank Draft Date" must be on the effective date. *If the draft date is other than the effective date,* ***we will draft in advance****.*

  Example: If a policy is issued on the 1st of the month with a request to draft on the 15th, *we will draft on the 15th of the preceding month*; *15 days before the first renewal date*. *Bank Drafts can only be drawn on the 1st through the 28th*. The actual date we draw payment from the applicant's account will be on or shortly after the chosen date, never before. Please include a voided check or a bank deposit slip (if available) with the application packet when selecting the Bank Draft option.

Business Checks

Business checks are only acceptable if they are submitted for the business owner or the owner's spouse.

Shortages

LifeShield will communicate with the agent by telephone, e-mail, or fax in the event of a premium shortage. The application will be held in pending until the balance of the premium is received. Agents may communicate with Underwriting by calling 844-649-1898 or by faxing 385-207-7882.

Refunds

LifeShield will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

General Administrative Rule – 12-Month Rate Guarantee

Our current administrative practice is to maintain rates for 12 months from the effective date of coverage.

APPLICATION

Properly completed paper applications should be finalized within 4-7 days of receipt at LifeShield's administrative office. The ideal turnaround time provided to the agent is 10-12 days, including mail time. Electronic applications processed within 24 hours. Time service may vary during times of high volume such as the Annual Enrollment Period.

Application Sections

The application must be ***completed in its entirety***. Review applications for the following information before submitting.

Part I & II – Personal Information and Plan Selection

Complete in full:

- Full Name (as shown on his/her Medicare ID Card)
- Residence Address
- Plan Applying for
- Medicare ID No., ***this is vital for electronic claims processing/payment***
- Age and Date of Birth of applicant, the age is based on the **effective date.**
- Gender
- Indicate if the applicant has used any tobacco products in the last 12 months
- Plan applied for – *Plan F is ONLY available to those first eligible for Medicare before 1/1/2020*

Part III – Eligibility

Complete in full:

- Indicate if the applicant is covered under Parts A and B of Medicare
- Indicate if the applicant turned 65 in the last 6 months

Part IV – Medicare & Insurance Information

- If applying during a guaranteed issue period – attach proof of eligibility
- **Verify if the applicant is covered through his/her state Medicaid program –** QUESTION 2

  If Medicaid is paying for benefits beyond the applicant's Part B premium or the Medicare Supplement premium for this policy, then the applicant is **not eligible** for coverage.

- If **leaving** a **Medicare Advantage plan**: complete QUESTION 3 and the Replacement Notice
- If **replacing** another **Medicare Supplement Policy**: complete QUESTION 4 and the Replacement Notice
- If applicant has had any other health insurance coverage in the past 63 days, including coverage through a union plan, employer group health plan, or other non-Medicare Supplement coverage, complete QUESTION 5
- Eligibility – Check the box indicating the type of eligibility applicant qualifies for: Open Enrollment, Guaranteed Issue, Underwritten
- **Requested Effective Date** – Can be elected on the application date and up to 60 days thereafter on underwritten business.

Part V – General Information Section

- Have applicant read this page, regarding medical coverage topics, prior to signing the application

Part VI – Household Premium Discount Information

- Indicate if the applicant is eligible for the household premium discount.
- If the applicant is eligible, provide household resident information and relationship to applicant.

Part VII – Premium Payment & Administration

Complete in full:

Premium Mode – Select desired frequency of premium payments from one of the following:

- **Annual** (payment made every 12 months)
- **Semiannual** (every six months)
- **Quarterly** (every three months), or
- **Monthly EFT (Electronic Funds Transfer)** (every month), **monthly premium payments cannot be on direct bill**

Initial Total Premium: Monthly Premium x Premium Mode + Policy Fee (one-time fee).

If authorizing bank draft payments:

- Select the **Monthly EFT** checkbox
- Draft Initial Premium on – select the box and provide the date they want the initial premium drawn from their account. (Must be 1st – 28th) – The first draft will occur on the date the Application is approved by the Company (unless specified otherwise)
- Check the **I authorize EFT Payments** Box
- Select Bank draft Day – Indicate desired bank draft day
    - (e.g., 1st-28th of the month). ***If the draft date is other than the effective date, we will draft in advance***
- Indicate if account is **Checking** or **Savings**
- Provide Bank Routing #, Bank Account #, Bank Name, Name(s) of Depositor(s)

  EFT is the only allowable form of payment for the E-application process. A paper application must be used if applicant is paying with direct bill.

Premium Payment by Social Security Schedule – if the bank draft is to be drawn on the day they receive their SSA Benefit, select the appropriate schedule.

Part VIII – Medical Questions

- Applicants applying during Open Enrollment or Guaranteed Issue periods, **DO NOT** need to answer the HEALTH QUESTIONS (1-15). **Note: Be sure to include documentation for GI eligibility**
- Applicants not considered to be in Open Enrollment or Guaranteed Issue periods need to answer all HEALTH QUESTIONS (1-15) on **Page 5** and prescription medication information on **Page 6,** if applicable. **In order to be considered eligible for coverage, all health questions (1-15) must be answered "No."**
- Provide the applicant's PRIMARY CARE PHYSICIAN INFORMATION on **Page 6**

Part IX – Agreement & Acknowledgement

- Applicant acknowledges receiving the Guide to Health Insurance and Outline of Coverage
- **Agent is required to leave these two documents with the client at the time the application is completed.**
- Applicant agrees to the Authorization to Disclose Personal Information
- Applicant signs and dates application
- Digital (Electronic) Signature/Date – **The agent is attesting to the fact they collected all information included in the web application (E-App) and the applicant consented to the use of his/her electronic signature when they type the applicant's name and their name on the signature line.**

If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative. POA applications are only allowed during Open Enrollment and Guarantee Issue periods.

Part X – Explanation of Benefits Delivery Agreement & Acknowledgement

This section gives the applicant the option of selecting Yes or No if they wish to receive electronic delivery of all contractual, regulatory, and administrative correspondence regarding their Medicare Supplement policy, to include claim correspondence, Explanations of Benefits, periodic notices (such as privacy notices) and other correspondence to the e-mail provided on the application along with the necessary computer software and equipment required.

Part XI – Agent Supplement

Representative/Agent(s) to complete information in this section, including:

- Did you meet with the Applicant in person?
- Did you complete this Application over the phone?
- State the name and relationship of another person present when this Application was taken.
- Did you review the Application for correctness and any omissions?
- Did the Applicant review the Application for correctness and any omissions?
- Are you related to the Proposed Insured? If yes, provide relationship.
- Listing of in force policies/certificates previously sold to the applicant.
- Agent name(s), signature(s), and date to acknowledge/certify the application information provided.
- Commission split, if applicable.

Part XII – Agent Comments

This section allows the agent to provide any additional information and/or comments they feel needs to be addressed regarding the application.

ELECTRONIC APPLICATION

Use of the electronic application by all agents is highly encouraged. The efficiency of the application, underwriting, policy issue, and commission payment process is greatly enhanced. Since it is not possible for an E-app to be submitted unless all required questions are answered, a telephone call to the applicant might be avoided. Power of attorney signatures are not accepted for electronic application.

Note: EFT is the only allowable form of payment for the E-application process. A paper application must be used if applicant is paying with direct bill.

The following are the instructions for completing each process. Please access the e-app through the agent portal or by using the following link.

https://lsneapp.com/forms/medicare

Open Enrollment

- Fully complete the application selecting the Open Enrollment option; you must adhere to your state regulatory requirements. (See pg. 6) The required payment option is EFT. Obtain the EFT information including the mode of premium. A request for funds is electronically submitted to the customer's bank upon approval of the policy, and LifeShield receives payment electronically. We cannot accept a credit card number or a debit card number for this process; we must have the numbers associated with the customer's checking or savings account. Applicants electing direct bill should complete a paper application and submit it via fax or mail.
- Once the application has been submitted, you can download or print the application if you wish. The applicant will show up in your agent portal for you to follow the status of the application.
- Special State Forms (where applicable) will be included with the web application for you to complete.

Guaranteed Issue

- During the application process, you will be prompted to upload all guaranteed issue documents required (i.e., copy of the termination letter, showing the date of and reason for termination, from the employer or group carrier, notice of termination from Medicaid or Medi-Cal, a copy of the applicant's MA plan's termination notice and any other document(s) relevant to the applicant's guaranteed issue situation).
- If any document(s) are not uploaded before submission, the application will automatically be pended in Underwriting and an e-mail sent noting the requirement(s) needed for review.
- If the requested Underwriting requirements are not received within 15 days of receipt of the email, the application will be closed out incomplete.

Underwriting Approval

- To qualify, the applicant needs to be able to answer the Medical Questions as "No" and the applicant must fall within the height/weight requirements. The applicant should not have any of the health conditions listed in the **Uninsurable Health Conditions** section and should not be taking any medication(s) listed in the **Partial List of Medications Associated with Uninsurable Health Conditions** section of this guide. If you have an applicant who has any medical history you feel should qualify, provide further detail for Underwriting consideration, and please submit the application in paper form.

Digital (Electronic) Signature & Date

- The agent is attesting to the fact they collected all information included in the web application (E-App). The applicant consented to the use of his/her electronic signature when he/she typed their name and the agent typed his/her name on the signature line. **Once you submit the application if you notice an omission or error, you should contact Underwriting immediately at 844-649-1898.**

HEALTH QUESTIONS

Unless an application is completed during open enrollment or a guaranteed issue period, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare Supplement coverage if any of the health questions are answered "Yes.

For a list of uninsurable conditions and the related medications associated with those conditions, please refer to the next two sections in this guide. There may, however, be situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition. Those conditions are listed in the health questions.

A condition is considered to be controlled if there have been no changes in treatment or medications for at least two years. If medications have been reduced (dosage or frequency) or removed; individual consideration will be given. If this situation exists and you would like consideration to be given to the application, answer the appropriate question "Yes," and attach an explanation stating how long the condition has existed and how it is being controlled. Be sure to include the name, dosage, frequency of all prescription medications and the diagnosis/medical condition given for each medication.

If you have questions about the interpretation of health questions addressing diabetes on the application, please see the information below:

- People with diabetes that has ever required more than 50 units of insulin daily are not eligible for coverage.
- People with diabetes (diet controlled, insulin dependent or treated with oral medications) who also have one or more of the complicating conditions listed in question 12 on the application, are not eligible for coverage.

Some additional questions to ask your client to determine if he/she does have a complication include:

1. Does he/she have eye/vision problems?
2. Does he/she have numbness or tingling in the toes or feet?
3. Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with well-controlled cases of hypertension and diabetes. A combination of one insulin and one oral medication would be the same as two oral medications. A case is considered to be well controlled if the person is taking no more than two oral medications for diabetes and no more than two medications for hypertension.

To verify stability, there should be no changes in the dosages or medications for at least two years. Individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower.

Uninsurable Health Conditions

Applications should not be submitted if applicant has the following conditions:

AIDS

Alzheimer's Disease

Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease)

ARC

Any cardiopulmonary disorder requiring oxygen

Cerebral Palsy

Chronic Kidney/Renal Disease

- Chronic Renal Insufficiency
- Chronic Nephritis
- Chronic Glomerulonephritis
- Chronic Protein Loss in the Urine (proteinuria) Requiring 4 or more MD visits per year in the follow up of renal disease
- Hypertensive Chronic Renal Disease
- Nephropathy
- Nephrotic Syndrome
- Stages 3, 4 or 5 Chronic Kidney Disease

Chronic Hepatitis

- Chronic Hepatitis B
- Chronic Hepatitis C
- Chronic Hepatitis D
- Autoimmune Hepatitis
- Chronic Steatohepatitis

Cirrhosis

Chronic Obstructive Pulmonary Disease ("COPD")

Other chronic pulmonary disorders to include:

- Asbestosis
- Bronchiectasis
- Chronic bronchitis
- Chronic Cardiopulmonary Disease
- Chronic obstructive lung disease ("COLD")
- Chronic asthma
- Chronic interstitial lung disease
- Chronic pulmonary fibrosis
- Cystic Fibrosis
- Emphysema
- Pulmonary Hypertension
- Sarcoidosis
- Scleroderma

***Diabetes – Insulin (>50 units/day)**

Kidney (Renal) Failure/End-stage Renal Disease (ESRD)

- Kidney Disease requiring dialysis
- Any kidney disorder that has the applicant being evaluated for or who is currently on dialysis

Lupus – Systemic

Multiple or Lateral Sclerosis

Myasthenia Gravis

Organ Transplant

Osteoporosis with fracture

Parkinson's Disease

Senile Dementia

Other cognitive disorders to include:

- Cerebrovascular Disease with cognitive deficits
- Delirium
- Dissociative Amnesia
- Huntington's Chorea (Huntington's Disease)
- Mild cognitive impairment ("MCI")
- Organic Brain Disorder
- Post-Concussion syndrome with residual deficit

In addition to the above conditions, the following will also lead to a decline:

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, further diagnostic evaluation, treatment, or therapy

Partial List of Medications Associated with Uninsurable Health Conditions

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

AIDS/HIV

- 3TC
- Aptivus
- Atripla
- AZT
- Combivir
- Crixivan
- D4T
- DDC
- DDI
- Emtriva
- Epivir
- Fuzeon
- Indinavir
- Interferon
- Invirase
- Kaletra
- Lexiva
- Nelfinavir
- Norvir
- Prezista
- Procrit
- Rescriptor
- Retrovir
- Reyataz
- Ritonavir
- Selzentry
- Sustiva
- Trizivir
- Valcyte
- Videx
- Viracept
- Viramune
- Viread
- Zerit
- Ziagen

ALS

- Radicaca
- Rilutek
- Riluzole

Alzheimer's Disease

- Aducanumab
- Aricept/Aricept ODT
- Donepezil
- Ebixa
- Memantine
- Namenda/Namenda XR
- Namzaric
- Razadyne
- Razadyne ER
- Rivastigmine Tartrate

Cancer

- Alkeran
- Herceptin
- Hydrea
- Hydroxyurea
- Interferon
- Leukeran
- Lomustine
- Megace
- Megestrol
- Melphalan
- Myleran
- Paraplatin
- Teslac
- Thiotepa
- VePesid
- Vincristine
- Zanosar
- Zoladex
- Zometa (Hypercalcemia in cancer)

Bladder Cancer

- BCG

Prostate Cancer

- Acetate
- Bicalutamide
- Casodex
- Eligard
- Leuprolide/Leuprolide Acetate
- Lupron Depot/Lupron Depot-Ped
- Provenge

CHF (Congestive Heart Failure)

- Natrecor

Partial List of Medications Associated with Uninsurable Health Conditions (continued)

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

CMV (Cytomegalovirus)

- Valcyte

COPD/Chronic Pulmonary Disorder

- Accuneb
- Anoro Ellipta
- Breo
- Brovana
- Daliresp
- Dornase Alfa
- DuoNeb
- Esbriet
- Incruse Ellipta
- Invacaftor
- Lumacaftor-Ivacaftor
- Nintedanib
- Nnitedanib Esylate
- Nucala
- OFEV
- Perfenidone
- Prednisone (>10 mg/day)
- Stiolto Respimat
- Trelegy Ellipta
- Turdoza
- Elexacaftor-Tezacafator-Ivacaftor

Dementia

- Aricept/Aricept ODT
- Cerefolin
- Cognex
- Ergoloid
- Exelon
- Galantamine
- Hydergine/Hydergine LC
- Metrifonate

Heart Disease

- Lasix/Furosemide (>60 mg/day)

Hepatitis

- Interferon

Immunosuppression

- Cytoxan
- Imuran
- Leukeran
- Neoral
- Sandimmune

Kidney Failure

- Epogen
- Procrit

Melanoma

- Hydroxyurea

Multiple Sclerosis

- Ampyra
- Aubagio
- Avonex
- Baclofen
- Bafiertam
- Betaseron
- Copaxone
- Extavia
- Gilenya
- Glatopa
- Kesimpta
- Lemtrada
- Lioresal
- Mavenclad
- Mayzent
- Mitoxantrone
- Novantrone
- Ocrevus
- Plegridy
- Ponvory
- Rebif
- Tecfidera
- Tysabri
- Vumerity
- Zinbryta

Partial List of Medications Associated with Uninsurable Health Conditions (continued)

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

Myasthenia Gravis

- Enlon
- Mytelase
- Prostigmin

Parkinson's Disease

- Amantadine
- Apokyn
- Artane
- Azilect
- Carbidopa
- Cogentin
- Comtan
- Eldepryl
- Exelon
- Kemadrin
- L-Dopa
- Levodopa
- Mirapex
- Neupro
- Parlodel
- Permax
- Requip
- Sinemet
- Stalevo
- Symmetrel
- Tasmar
- Zelapar

Psychosis

- Haldol
- Mellaril
- Navane
- Prolixin
- Risperdal
- Stelazine
- Thorazine

Pulmonary Hypertension

- Letairis
- Remodulin

Rheumatoid Arthritis

- Embrel
- Gold
- Methotrexate
- Prednisone (>10 mg/day)
- Remicade

Schizophrenia

- Geodon
- Invega
- Ziprasidone

Severe Arthritis

- Cytoxan
- Imuran
- Leukeran
- Neoral
- Sandimmune

REQUIRED FORMS

Application

Only current Medicare Supplement applications may be used in applying for coverage. A copy of the completed application will be made by LifeShield and attached to the policy to make it part of the contract. The agent is responsible for submitting applications to LifeShield's administrative office.

Health Information Authorization (HIPAA Required Authorization) Form

Required with all underwritten applications.

Replacement Form

The replacement form must be signed and submitted with the application when replacing any Medicare Supplement or Medicare Advantage plan. A signed replacement notice must be left with the applicant; a second signed replacement notice must be signed with the application.

Agent or Witness Certification for Non-English Speaking and/or Reading Applicants

A form signed and dated by the agent and/or witness stating they spoke in the language of the applicant and have accurately translated and read to the applicant all questions on the application and all forms required to be submitted with the application for insurance. The agent and/or witness have accurately translated and recorded the applicant's responses to all questions on the application and all other forms submitted with the application and they are not a family member or relative of the applicant.

STATE SPECIAL FORMS

Forms specifically mandated by states to accompany point of sale material. All forms will be part of the supplies with the app packet. **Any form(s) that need to be returned will be made part of the new business submission packet.**

COLORADO
Commission Disclosure Form – This form is to be completed by the Agent, then signed by the Agent and Applicant. A copy must be submitted with the application and a copy left with the Applicant.

FLORIDA
Agent Certification Form – This form is to be completed by the agent; signed by the agent and applicant and submitted with the application.

ILLINOIS
Medicare Supplement Checklist – The Checklist must be completed and submitted with the application and a copy left with the applicant.

INDIANA
Notice to Policyholders regarding filing complaints with the Department of Insurance – This form is to be left with the applicant.

IOWA
Important Notice before You buy Health Insurance – To be left with the Applicant.

KENTUCKY
Comparison Statement – This form is to be completed by the agent; signed by the agent and applicant and submitted with the application.

LOUISIANA
Your Rights Regarding the Release and Use of Genetic Information – This form is to be left with the applicant.

MARYLAND
Eligible Persons for Guarantee Issue and Open Enrollment – This form is to be left with the applicant.

MINNESOTA
Agent Information Form – This form is to be completed and signed by the Agent and left with the applicant.

NEBRASKA
Senior Health Counseling Notice – This form is to be left with the applicant.

NEW MEXICO
New Mexico Confidential Abuse Information – Optional form, submit copy if completed.

OHIO
Solicitation and Sale Disclosure – This form is to be left with the applicant.

PENNSYLVANIA
Eligible Persons for Guarantee Issue and Open Enrollment – This form is to be left with the applicant.

SOUTH CAROLINA
Duplication of Insurance – Forms should be completed and submitted with the application when duplicating Medicare Supplement insurance with other health insurance.

TEXAS
Toll-Free Complaint Notice and Definition of Eligible Person for Guaranteed Issue Notice – These notices must be provided to the client.