Home Office: Jefferson City, MO
Administration: P.O. Box 10874
Clearwater, Florida 33757-8874

LUMICO LIFE INSURANCE COMPANY

Lumico life insurance

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION I. PROPOSED INSURED INFORMATION

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

First Name	Middle Initial	Last Name
Resident Address		Phone *(with area code)*
City		Date of Birth (*MM/DD/YYYY)*
State	Zip Code	Age (*at Effective Date)*
Mailing Address (if different from Resident Address)		Email Address
City		Male ☐ Female ☐
State	Zip code	Social Security Number
Medicare Card Beneficiary Identification Number		

SECTION II. PLAN AND PREMIUM INFORMATION

Plan	Requested Policy Effective Date	Household Premium Discount Yes ☐ No ☐ *If you answered Yes, please complete the Household Discount form.*
Modal Premium $		Policy Fee $
Premium Collected $		Payment Method: Bank Draft ☐ Direct Bill ☐
Payment Mode:	Monthly ☐ (Bank Draft ONLY)	Annual ☐ Semi-Annual ☐ Quarterly ☐

SECTION III. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

You may qualify for Medicare if you are under the age of 65 and disabled.

1. Within the past 12 months, have you used any tobacco or nicotine products, including cigarettes, cigars, eCigarettes, vape, chewing tobacco, pipe, or nicotine gum/patch? Yes ☐ No ☐
2. Are you covered under Medicare Part A? Yes ☐ No ☐

   If NO, what is your future Part A eligibility date? (*MM/DD/YYYY*) _____

   If YES, what is your Part A effective date? (*MM/DD/YYYY*) _____

SECTION III. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS (continued)

3. Are you covered under Medicare Part B? Yes ☐ No ☐

   If NO, what is your future Part B eligibility date? (*MM/DD/YYYY*) _____

   If YES, what is your Part B effective date? (*MM/DD/YYYY*) _____

4. Have you enrolled in Medicare Part B more than once? Yes ☐ No ☐

5. Are you applying during a guaranteed issue period? (If YES you must attach proof of eligibility). Yes ☐ No ☐

6. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)? Yes ☐ No ☐

   IF YES, please check the box that applies. ☐ Disability ☐ End Stage Renal Disease (ESRD)

SECTION IV. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to **SECTION VII**.
If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.
If you answer YES to any of the following questions 2 – 9, you are not eligible for coverage.

1. Height (*Feet and inches*):_____ Weight (*Pounds*):_____

2. Are you bedridden, confined to a wheelchair, or do you require the assistance of a motorized mobility device, or have you had any amputation caused by disease? Yes ☐ No ☐

3. Are you currently hospitalized, in a nursing home or assisted living facility, or have you been hospitalized three or more times in the past two years? Yes ☐ No ☐

4. Are you currently receiving any occupational, speech, or physical therapy, or are you currently using the services of a home healthcare agency? Yes ☐ No ☐

5. Have you been advised by a physician to have surgery (including cataract or joint replacement surgery), medical tests, infusions, or therapy that has not been performed? Yes ☐ No ☐

6. At any time, have you had, been medically diagnosed with, or treated for any of the following:

   a. Parkinson's disease, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia, or any other cognitive disorder? Yes ☐ No ☐

   b. Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC), or human immunodeficiency virus (HIV) infection? Yes ☐ No ☐

   c. Chronic kidney disease stage 3-5, or kidney insufficiency, or renal failure requiring dialysis? Yes ☐ No ☐

   d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic pulmonary condition, or any medical condition requiring the use of oxygen? Yes ☐ No ☐

   e. Systemic lupus, scleroderma, or myasthenia gravis? Yes ☐ No ☐

   f. An organ transplant or been advised to have an organ transplant (excluding cornea transplants)? Yes ☐ No ☐

   g. Chronic hepatitis or cirrhosis of the liver? Yes ☐ No ☐

   h. Cardiac defibrillator implanted? Yes ☐ No ☐

SECTION IV. HEALTH QUESTIONS (continued)

7. Within the past two years, have you had any of the following:

   a. Heart attack, cardiac angioplasty, bypass surgery, or stent placement or replacement? Yes ☐ No ☐

   b. Vascular angioplasty, endarterectomy, or implantation of a pacemaker? Yes ☐ No ☐

   c. A stroke or transient ischemic attack (TIA)? Yes ☐ No ☐

8. Within the past two years have you had, been treated for, or been advised by a physician to have treatment for:

   a. Alcoholism or drug abuse? Yes ☐ No ☐

   b. Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐

   c. Arthritis that restricts mobility? Yes ☐ No ☐

9. If you have diabetes or take medication to control your blood sugar, please answer each of the following questions (a-d); otherwise, answer each question NO.

   a. Have you ever required or been advised to take more than fifty (50) units of insulin daily? Yes ☐ No ☐

   b. Do you take three (3) or more medications (oral or injections) to control your blood sugar? Yes ☐ No ☐

   c. Do you take four (4) or more medications to control your high blood pressure? Yes ☐ No ☐

   d. Have you been diagnosed with or treated for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney disease, kidney failure, stroke, TIA, congestive heart failure, or any heart disorder? Yes ☐ No ☐

SECTION V. CONSIDERATION HEALTH QUESTIONS

If you answer YES to any of the following health questions, your application will be submitted to underwriting for review.

10. Are you currently receiving, or have you been advised to receive injections in a physician's office? Yes ☐ No ☐

11. Within the past two years have you had or been treated for or been advised by a physician to have treatment for:

   a. Coronary artery disease, angina, aortic or cardiac aneurysm, cardiomyopathy, congestive heart failure, heart valve disorder, atrial fibrillation, or other heart rhythm disorder? Yes ☐ No ☐

   b. Peripheral artery disease, peripheral vascular disease, peripheral venous thrombotic disease, or carotid artery disease? Yes ☐ No ☐

   c. Degenerative bone disease, spinal stenosis, or rheumatoid arthritis? Yes ☐ No ☐

   d. Any mental or nervous disorder requiring treatment by a psychiatrist? Yes ☐ No ☐

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

SECTION VI. MEDICATION HISTORY

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

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

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

SECTION VII. REPLACEMENT 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 insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐
   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐
   (c) If YES, indicate your effective date (*MM/DD/YYYY*). _____
   (d) Did you enroll in Medicare Part C in the last six months? Yes ☐ No ☐
   (e) If YES, indicate your effective date. (MM/DD/YYYY) _____
   (f) Did you enroll in Medicare Part D in the last six months? Yes ☐ No ☐
   (g) If YES, indicate your effective date (MM/DD/YYYY). _____
2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐
   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)
   If YES, answer (a) – (b) below.
   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐
   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐
3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.) Yes ☐ No ☐
   If YES, answer (a) – (g) below.
   (a) Name of Company .....
   Plan Type & Policy/Certificate No .....
   Company Telephone Number .....
   Coverage Dates (*MM/DD/YYYY*): START DATE _____
   (if you are still covered under this plan, leave end date blank) END DATE _____
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐
   If YES, have you received a copy of the replacement notice? Yes ☐ No ☐
   (c) Reason for termination/disenrollment? .....
   (d) Planned date of termination/disenrollment? (*MM/DD/YYYY*) _____
   (e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐
   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐
   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐
4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes ☐ No ☐
   If YES, answer (a) – (d) below.
   (a) Name of Company .....
   Plan Type & Policy/Certificate No .....
   Company Telephone Number .....
   Issue Date (*MM/DD/YYYY*) _____
   (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐
   (c) Indicate termination date (*MM/DD/YYYY*). _____
   (d) Have you received a copy of the replacement notice? Yes ☐ No ☐

SECTION VII. REPLACEMENT QUESTIONS (continued)

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

If YES, answer (a) – (c) below.

(a) Name of Company

Plan Type & Policy/Certificate No

Company Telephone Number

Coverage Dates (*MM/DD/YYYY*): START DATE

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

(b) Reason for termination/disenrollment?

(c) Planned date of termination/disenrollment (*MM/DD/YYYY*)?

SECTION VIII. AGENT CERTIFICATION

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

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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

SECTION IX. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- 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. Upon receipt of timely notice, the issuer must either return to the policyholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. 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.
- 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 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).

SECTION X. ELECTRONIC AND/OR TELEPHONIC INSTRUCTIONS.

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

☐ I authorize the Company to act on electronic and/or telephonic instructions.

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

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

☐ I authorize the Company to electronically deliver statements and other documents. I do have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address.

☐ I DO NOT authorize the Company to electronically deliver statements and other documents.

SECTION XI. CERTIFICATION

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

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

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

Signed at: _____ _____ _____

State | Applicant's Signature | Date

Agent Writing Number

_____ _____

Agent's Signature | Date

Policy Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant

LUMICO LIFE INSURANCE COMPANY

Home Office: Jefferson City, Missouri
Administration: P.O. Box 10874
Clearwater, Florida 33757-8874

Medicare Supplement Household Discount Form

Applicant Name:	Applicant Social Security Number:

To qualify for the Household discount, the applicant must meet one of the following criteria below. Please select the box which applies:

☐ I am currently married and have been residing with my spouse named below for at least the last 12 months.

☐ I have been residing with the person named below for at least the last 12 months.

Spouse or Additional Resident Name:		
Address:	City:	State: Zip Code:
Last Four Digits of Social Security Number:		Date of Birth (mm/dd/yyyy):
Relationship to Applicant:		

If the spouse/additional resident named above currently has a Lumico Life Medicare Supplement policy (Policy #_____) the discount will be applied to both policies.

Agent/Applicant Signature:

By signing this form I certify that I qualify for the household discount by meeting the criteria listed above.

_____

Agent Signature Date

_____

Applicant Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE LUMICO LIFE INSURANCE COMPANY

Home Office: Jefferson City, MO 65101
Medicare Supplement Administrative Office: P. O. Box 10874, Clearwater, Florida 33757-8874

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

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement 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 AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement 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.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

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

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

_____
Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE LUMICO LIFE INSURANCE COMPANY

Home Office: Jefferson City, MO 65101
Medicare Supplement Administrative Office: P. O. Box 10874, Clearwater, Florida 33757-8874

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

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement 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 AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement 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.

_____ No change in benefits, but lower premiums.

_____ Fewer benefits and lower premiums.

_____ Change in benefits. **(Gaining additional benefit(s) but losing some existing benefit(s)).**

_____ My plan has outpatient drug coverage and I am enrolling in Part D.

_____ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____ Other (please specify) _____

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

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

_____
Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

_____ _____
Applicant's Signature Date

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

Montana Guaranteed Issue Checklist	Plans Available for Policy Effective dates on or after 1/1/2020 (if offered)
☐ The individual is enrolled under an employee welfare benefit plan that is ***primary*** to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan. **Acceptable Proof:** A copy of the personalized Certificate of Creditable Coverage or letter from the employer indicating the coverage was ***primary*** to Medicare for all individuals covered. ☐ The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits (pays secondary) under Medicare and the plan terminates or ceases to provide some or all such supplemental health benefits. **Acceptable Proof:** A personalized letter from the employer reflecting the date of the loss of coverage ***and*** the reason for the loss of coverage for all individuals covered. ***(Please note: a Certificate of Creditable Coverage does not typically indicate the reason for the loss of coverage.)***	
☐ Enrolled in a Medicare Advantage plan, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE), or enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or discontinues including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual. ***Acceptable Proof:*** A copy of the personalized letter from the Medicare Advantage Company indicating they are leaving the Medicare program, or the plan will no longer service the area/region, or the person has moved outside of the coverage area. A copy of the report from the state's Department of Insurance documenting a violation or misrepresentation.	A, B, D, G, High Ded. G, K or L (if 'Newly Eligible') A, B, C, F, High Ded F, K or L (if **NOT** 'Newly Eligible')
☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material marketing misrepresentation. ***Acceptable Proof:*** A copy of the report from the state's Department of Insurance documenting the violation or misrepresentation.	
☐ Enrolled under a Medicare Supplement policy, terminates that coverage and enrolls for the first time in a Medicare Advantage, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment. **Please note: the client must go back to their previous Medicare Supplement carrier as guaranteed issue, if the plan is still available. If the previous carrier no longer issues coverage, the applicant is GI with any carrier.** ***Acceptable proof:*** A copy of the Policy Schedule Page or ID Card, or other documentation for the previous Medicare Supplement provider that includes the effective date, plan and termination date ***and*** a copy of the personalized disenrollment letter from the Medicare Advantage provider. If the disenrollment letter doesn't include the effective date, a copy of the ID card is needed.	

☐ Upon first becoming eligible for benefits under Part A, enrolls in a Medicare Advantage or PACE provider plan and then disenrolls by no later than 12 months after the effective date. ***Acceptable Proof:*** A copy of the personalized disenrollment letter from the Medicare Advantage Company ***and*** a copy of the ID Card or other personalized document showing the effective date of the plan.	Any plan sold by the company in the applicant's residence state (Newly Eligible applicants may not be sold Plans C, F or High Ded F)
☐ Upon first becoming eligible for benefits under Part A and Part B is enrolled in the Qualified Medicare Beneficiary Program or Medicaid and no longer qualifies due to income or eligibility changes. ***Acceptable Proof:*** A copy of the personalized eligibility/determination letter from the state Medicaid program that includes the benefits the client was receiving, the termination date ***and*** the reason for the loss of benefits.	
☐ Upon first becoming eligible for benefits under Part A and Part B enrolls in the Montana Comprehensive Health Association (high risk pool) and coverage under the Montana Comprehensive Health Association terminates. ***Acceptable Proof:*** A personalized letter from the plan provider reflecting the date of the loss of coverage ***and*** the reason for the loss of coverage.	

Definition of Newly Eligible:

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

(a) Applicant was born ***on or after*** 1/1/1955 **AND**

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

Lumico
insurance made clear

AUTHORIZATION FOR RELEASE OF PERSONAL AND MEDICAL INFORMATION

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health information exchange, health plan, health insurance plan, health care provider or health care facility, health care professional, clinic, laboratory, medical facility, governmental agency, any insurance company or any other entity that has any diagnosis, prescription or other medical information about me, to disclose my entire medical record and any other protected health information including, the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection, sexually transmitted diseases, mental illness, alcohol, drugs, and tobacco to Lumico Life Insurance Company or its reinsurers, employees, or representatives ("Lumico"). This authorization overrides any restrictions that I may have in place with any entity regarding the release of my medical information. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

Lumico and its affiliates may use and disclose information received under these authorizations where required to underwrite your application or if not required, for insurance related operations, to obtain reinsurance and for any purposes described in this consent. Lumico may use and analyze this information for any purposes permitted by law, including general underwriting and insurance purposes, improving products and services, enhancing account administration, internal risk controls, fraud detection, product research and development, and marketing.

These authorizations shall be valid for 30 months from this date, or the time limit permitted by law in the state where the policy is issued, and you may revoke it at any time by sending written notice to Lumico at P.O. Box 10875, Clearwater, FL 33757-8875. Lumico may use your information for an unlimited period for general underwriting and insurance purposes and to improve the products and services.

By signing, I acknowledge that I have read or been read and agree to the authorizations above, and that I have read or been read and agree to this Authorization for Release of Personal and Medical Information.

Name of Proposed Insured	**Date of Birth (mm/dd/yyyy)**

Signature	**Date**

Lumico life insurance

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

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

ELECTRONIC PAYMENT AUTHORIZATION FORM

Insured Name: _____ Insurance Policy Number: _____

Sign and date this authorization below

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

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

Section 1 – Select one of the following date options

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

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

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

- ☐ 1st day of the Month
- ☐ 3rd day of the Month
- ☐ 2nd Wednesday of the Month
- ☐ 3rd Wednesday of the Month
- ☐ 4th Wednesday of the Month

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

☐ Other, please specify a day of the month from the 1st to 28th _____
(if this date falls on a weekend or holiday, deduction will be on the next business day)

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

☐ Checking ☐ Savings

Accountholders Signature: _____ Date: _____

Attach void check here

or complete information below

Accountholders Name: _____

Branch/Bank Name: _____

Routing number: _____

Account Number: _____