Elips Life Insurance Company
Home: [1450 American Lane, Suite 1100,Schaumburg, IL 60173]
Admin: [P.O. Box 10874, Clearwater, FL 33757]
[Elipslife.lumico.com]

MEDICARE SUPPLEMENT COVERAGE APPLICATION

SECTION I – Proposed Insured information

APPLICANT NAME *(exactly as it appears on your Medicare Health Insurance card)*

First name	**Middle initial**	**Last name**

Date of birth *(MM/DD/YYYY)*	**Age** *(at Effective Date)*	**Social Security Number**

Gender *(select one)*	**Phone number(s)** *(with area code)*
☐ Male ☐ Female	*Mobile:* *Home:*

Resident address

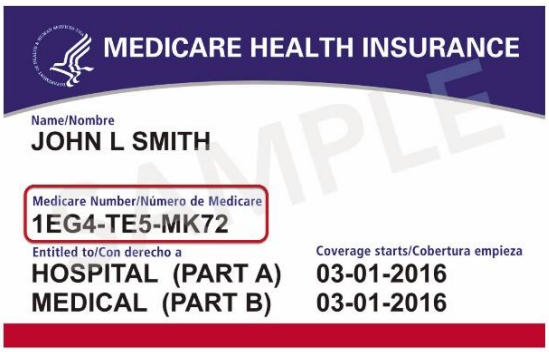
City	**State**	**ZIP code**

Mailing address *(if different from Resident address)*

City	**State**	**ZIP code**

Medicare Number *(exactly as it appears on your Medicare Health Insurance card; see below sample)*

Medicare Health Insurance card sample:



ALL PAGES OF THE APPLICATION MUST BE SUBMITTED

SECTION II – Plan and payment information

Plan	Requested policy effective date

*Only those applicants who are initially eligible for Medicare before January 1, 2020 may apply for Plan F.

Household premium discount

☐ Yes *(please complete the Household Discount form)* ☐ No

Modal Premium	Policy fee	Premium collected*
$	$	$

***Only one month's premium is required at the time of application.**

Payment method *(select one):*	**Payment mode** *(select one):*
☐ Billed *(select one):*	☐ Quarterly ☐ Semi-annual ☐ Annual
☐ Bank draft *(select one):*	☐ Monthly *(bank draft only)* ☐ Quarterly ☐ Semi-annual ☐ Annual

SECTION III – Eligibility questions ***(please answer all questions)***

1. 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? *(See "Coverage starts" on your Medicare Health Insurance card. MM/DD/YYYY)*		
2. 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? *(See "Coverage starts" on your Medicare Health Insurance card. MM/DD/YYYY)*		
3. Have you enrolled in Medicare Part B more than once?	☐ Yes	☐ No
4. Are you applying during a guaranteed issue period? (If *YES,* you must attach your proof of eligibility to this application.)	☐ Yes	☐ No
5. 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)		

If you are applying during an *Open Enrollment* or a *Guaranteed Issue* period, **go to SECTION VII – Replacement questions**.

If not, please proceed **to SECTION IV – Health questions**.

SECTION IV – Health questions

If you are applying during your Open Enrollment period or qualify for Guaranteed Issue, SKIP THIS SECTION and go to SECTION VII. Refer to SECTION IX for assistance in determining if you qualify for either Open Enrollment or Guaranteed Issue.

If you do not qualify for Open Enrollment or Guaranteed Issue , please answer ALL of the following questions. For questions 2-10, please answer with Yes (Y), No (N), or Not Sure (NS).

[If you answer *YES* to any questions from 3 to 10 in this section, you are not eligible for coverage.]

1.	Height *(feet and inches)*: Weight *(pounds)*:			
2.	Within the past twelve (12) months, have you used any tobacco or nicotine products, including: - cigarettes - cigars - pipes - vapes - chewing tobacco - nicotine gum/patches - eCigarettes	☐ Y	☐ N	☐ NS
3.	- Are you bedridden or confined to a wheelchair, - do you require the assistance of a motorized mobility device, or - have you had any amputation caused by disease?	☐ Y	☐ N	☐ NS
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?	☐ Y	☐ N	☐ NS
5.	Are you currently receiving any: - occupational, speech, or physical therapy, or - services from a home healthcare agency?	☐ Y	☐ N	☐ NS
6.	Have you been advised by a physician to have any of the following that have not been performed: - surgery (including cataract or joint replacement surgery), - medical tests, infusions, or therapy?	☐ Y	☐ N	☐ NS
7.	Have you had, been medically diagnosed with, or treated at any time for any of the following:			
	a) Cognitive or nervous system disorders: i) Parkinson's disease ii) Dementia iii) Multiple or amyotrophic lateral sclerosis iv) Muscular Dystrophy v) Alzheimer's disease vi) Any other cognitive disorder?	☐ Y	☐ N	☐ NS
	b) - Acquired immune deficiency syndrome (AIDS), or - AIDS related complex (ARC)? **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**	☐ Y	☐ N	☐ NS
	c) - Chronic kidney disease [stage 3-5], - kidney insufficiency, or - renal failure requiring dialysis?	☐ Y	☐ N	☐ NS
	d) - Emphysema, - chronic obstructive pulmonary disease (COPD), - any other chronic pulmonary condition, or - any medical condition requiring the use of oxygen?	☐ Y	☐ N	☐ NS

SECTION IV – Health questions *(continued)*

e)	Systemic lupus, - scleroderma, or - myasthenia gravis?	☐ Y	☐ N	☐ NS
f)	An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	☐ Y	☐ N	☐ NS
g)	Chronic hepatitis or cirrhosis of the liver?	☐ Y	☐ N	☐ NS
h)	Cardiac defibrillator implantation?	☐ Y	☐ N	☐ NS
8.	Have you had any of the following in the last two (2) years:			
a)	- Heart attack, - bypass surgery, - cardiac angioplasty, or - stent placement or replacement?	☐ Y	☐ N	☐ NS
b)	Vascular angioplasty - implantation of a pacemaker? - endarterectomy, or	☐ Y	☐ N	☐ NS
c)	A stroke or transient ischemic attack (TIA)?	☐ Y	☐ N	☐ NS
9.	Have you had, been treated for, or been advised by a physician within the last two (2) years to have treatment for:			
a)	Alcoholism or drug abuse?	☐ Y	☐ N	☐ NS
b)	- Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), - leukemia, - melanoma, - Hodgkin's disease, or - lymphoma?	☐ Y	☐ N	☐ NS
c)	Arthritis that restricts mobility?	☐ Y	☐ N	☐ NS
10.	Do you have diabetes or take medication to control your blood sugar? If *YES*, please answer each of the following questions (a to d). If *NO*, please answer each question (a to d) with '*NO*'.	☐ Y	☐ N	☐ NS
a)	Have you ever required or been advised to take more than fifty (50) units of insulin daily?	☐ Y	☐ N	☐ NS
b)	Do you take three (3) or more medications (oral or injections) to control your blood sugar?	☐ Y	☐ N	☐ NS
c)	Do you take [four (4)] or more medications to control your high blood pressure?	☐ Y	☐ N	☐ NS
d)	Have you been diagnosed with or treated for any of the following conditions: - peripheral vascular disease, - stroke, - peripheral venous thrombotic disease, - transient ischemic attack (TIA), - peripheral artery disease, - congestive heart failure, or - kidney disease, - any heart disorder? - kidney failure,	☐ Y	☐ N	☐ NS

SECTION V – Consideration health questions

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

11. Are you currently receiving, or have you been advised to receive injections in a physician's office?	☐ Y	☐ N	☐ NS
12. Have you had or been treated for or been advised by a physician to have treatment within the last two (2) years for:			
a) - Coronary artery disease, - angina, - aortic or cardiac aneurysm, - cardiomyopathy, or - congestive heart failure, - heart valve disorder, - atrial fibrillation, - other heart rhythm disorder?	☐ Y	☐ N	☐ NS
b) - Peripheral artery disease, - peripheral vascular disease, or - peripheral venous thrombotic disease, - carotid artery disease?	☐ Y	☐ N	☐ NS
c) - Degenerative bone disease, - spinal stenosis? - rheumatoid arthritis, or	☐ Y	☐ N	☐ NS
d) Any mental or nervous disorder requiring treatment by a psychiatrist?	☐ Y	☐ N	☐ NS

If you answered *YES* to any of the questions in this section (V), please provide dates and details regarding your treatment below.

SECTION VI – Medication history

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

If you answered *YES* to the above question, 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 *(MM/DD/YYY)*:	
Date prescription **last filled** *(MM/DD/YYYY):*	
Dosage and frequency:	
Diagnosis/condition:	

Medication name *(copy off pharmacy label)*:	
Date **originally** prescribed *(MM/DD/YYY)*:	
Date prescription **last filled** *(MM/DD/YYYY):*	
Dosage and frequency:	
Diagnosis/condition:	

Medication name *(copy off pharmacy label)*:	
Date **originally** prescribed *(MM/DD/YYY)*:	
Date prescription **last filled** *(MM/DD/YYYY):*	
Dosage and frequency:	
Diagnosis/condition:	

ATTACH A SEPARATE SHEET IF NEEDED

SECTION VII – Replacement questions

You may be guaranteed acceptance in one or more of our Medicare supplement plans, **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.
- You had certain rights to buy such a policy.

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 65 years of age in the last six months?	☐ Yes	☐ No
b)	Did you enroll in Medicare Part B in the last six months?	☐ Yes	☐ No
	If *YES*, what is your effective date? *(From Medicare Health Insurance card, MM/DD/YYYY)*.		
2.	Are you covered for medical assistance through California's Medi-Cal program? *NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer* NO *to this question.*	☐ Yes	☐ No
	If *YES*, please answer questions a) and b) below.		
a)	Will Medi-Cal pay your premiums for this Medicare supplement policy?	☐ Yes	☐ No
b)	Do you receive any benefits from Medi-Cal *OTHER THAN* payments toward your Medicare Part B premium?	☐ Yes	☐ No
3.	Have you had coverage from any Medicare plan other than original Medicare within the past sixty three (63) days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)	☐ Yes	☐ No
	If *YES*, please answer questions a) and b) below.		

a)	Name of company:	
	Plan type & policy/certificate no.:	
	Company telephone number:	
	Coverage dates *(MM/DD/YYYY):*	*Start date:* *End date:* *If you are still covered under this plan, leave end date blank.*

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
c)	Was this your first time in this type of Medicare plan?	☐ Yes	☐ No
d)	Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes	☐ No

SECTION VII – Replacement questions *(continued)*

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

If *YES,* please answer questions a) and b) below.

a)	Name of company:	
	Plan type & policy/certificate no.:	
	Company telephone number:	
	Issue date *(MM/DD/YYYY):*	

b)	Do you intend to replace your current Medicare supplement policy with this policy?	☐ Yes	☐ No
5.	Have you had coverage under any other health insurance within the past sixty three (63) days? (For example, an employer, union, or individual plan.)	☐ Yes	☐ No

If *YES,* please answer below.

Name of company	
Plan type & policy/certificate no.	
Company telephone number	
Coverage dates *(MM/DD/YYYY)*	*Start date:* *End date:* *If you are still covered under this plan, leave end date blank.*

SECTION VIII – Agent certification

THIS SECTION IS FOR AGENTS ONLY – agents will 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:	

SECTION VIII – Agent certification *(continued)*

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:	
Name of company:	
Policy/certificate number:	
Description of benefits:	
Effective date of coverage:	

SECTION IX – Open enrollment and guaranteed issue eligibility

If You are eligible for Open Enrollment or Guaranteed Issue, you will not need to answer Sections IV, V and VI on pages 3 through 6 of this application.

Open Enrollment: The following are the requirements of individuals who are eligible for Open Enrollment:

a. A policy or certificate that is submitted prior to or during the six-month period beginning with the first day of the first month in which an individual is both 65 years of age or older and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate currently available from an issuer shall be made available to all applicants who qualify under this subdivision and who are 65 years of age or older.

b. An issuer shall make available Medicare supplement benefit plans A, B, D and G if currently available to an applicant who qualifies under this subdivision who is 64 years of age or younger and who does not have end-stage renal disease. An issuer shall also make available to those applicants Medicare supplement benefit plan K or L, if currently available, or Medicare supplement benefit plan M or N, if currently available. The selection between Medicare supplement plan K or L and the selection between Medicare supplement benefit plan M or N shall be made at the issuer's discretion.

c. An individual enrolled in Medicare by reason of disability shall be entitled to open enrollment for six months after the date of enrollment in Medicare Part B, or if notified retroactively of eligibility for Medicare, for six months following notice of eligibility.

d. An individual enrolled in Medicare Part B is entitled to open enrollment for six months following receipt of a notice of termination or, if no notice is received, the effective date of termination from any employer sponsored health plan including an employer-sponsored retiree health plan, receipt of a notice of loss of eligibility due to the divorce or death of a spouse or, if no notice is received, the effective date of loss of eligibility due to the divorce or death of a spouse, from any employer-sponsored health plan including an employer-sponsored retiree health plan, or termination of health care services for a military retiree or the retiree's Medicare eligible spouse or dependent as a result of a military base closure or loss of access to health care services because the base no longer offers services or because the individual relocates.

e. An individual enrolled in Medicare Part B is entitled to open enrollment if the individual was covered under a policy, certificate, or contract providing Medicare supplement coverage but that coverage terminated because the individual established residence at a location not served by the plan.

f. An individual whose coverage was terminated by a Medicare Advantage plan shall be entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation, for any Medicare supplement coverage provided by a Medicare supplement issuers and available on a guaranteed basis under state and federal law or regulation for persons terminated by their Medicare Advantage plan.

g. An individual shall be entitled to an annual open enrollment period lasting 60 days or more, commencing with the individual's birthday, during which time that person may purchase any Medicare supplement policy, that offers benefits equal to or lesser than those provided by the previous coverage.

h. An individual enrolled in Medicare Part B is entitled to open enrollment upon being notified that, because of an increase in the individual's income or assets, they meet one of the following requirements: (1) they are no longer eligible for Medi-Cal benefits or (2) they are only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that they have not met the share of cost.

SECTION IX – Open enrollment and guaranteed issue eligibility (continued)

Guaranteed Issue For Eligible Persons: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue:

a. Enrolled under an employee welfare benefit plan that provides health benefits under Medicare and either of the following applies: (1) the plan either terminates or ceases to provide all of those supplemental health benefits to the individual; or (2) the employer no longer provides the individual with insurance that covers all of the payment of the 20% coinsurance; or

b. Enrolled in a Medicare Advantage plan, Program of All-Inclusive Care for the Elderly (PACE), or any similar organization operating under demonstration project authority and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated for all individuals within a residence area, the organization substantially violated a material policy provision, a material misrepresentation was made to the individual, the organization, or agent, or other entity acting on the organizations behalf materially misrepresented the plan's provisions in marketing the plan to the individual, or the individual meets other exceptional conditions as the Secretary may provide; or

c. Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and premiums or copayments increase by 15% or more, benefits are reduced, or the provider contract is terminated with the medical provider treating the individual; or

d. 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 specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated for all individuals within a residence area, the organization, or agent, or other entity acting on the organization's behalf substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

e. Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, bankruptcy or other involuntary termination of coverage or enrollment under the policy, substantial violation of a material policy provision, or material misrepresentation; or

f. Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then terminates coverage within 12 months of enrollment; or

g. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy; or

h. Upon first becoming enrolled for benefits under Medicare Part A at age 65, enrolled in a Medicare Advantage plan under Medicare Part C or Medicare, or with a PACE provider under Section 1894 of the federal Social Security Act, and then disenrolls from the plan or program not later than twelve (12) months after the effective date of enrollment.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

SECTION X – Important statements to be read by the 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 Medi-Cal and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, 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 Medi-Cal eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in, a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services are available in this state to provide advice concerning your purchase of a Medicare supplement Insurance and concerning medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, or access the department's Internet Web site, www.insurance.ca.gov, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.
- A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's internet website (www.insurance.ca.gov).

SECTION XI – Electronic and/or telephonic instructions

In order to process your signature, the Company requests your authorization 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.

The company also requests your authorization to deliver statements and other documents electronically, **such as by email or Internet**. (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 XII – Signature and final acknowledgments

To the best of my knowledge and belief, all of the answers to the questions contained in this application are accurate 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.**

(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 the agent had read to the applicant, the completed application. The agent has explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information on the application and the applicant understood the explanation. 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.

Notice: If you state as an agent any material fact that you know to be false, you are subject to a civil penalty of up to ten thousand dollars ($10,000).

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 medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10874, Clearwater, FL 33757
Elipslife.lumico.com

ELI-MS-HHD-2021-001-CA

MEDICARE SUPPLEMENT
HOUSEHOLD DISCOUNT FORM

APPLICANT

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 residing with my spouse (this includes validly recognized civil union and domestic partners) named below

☐ I have been residing with the person named below who is age 50 or older for at least the last 12 months.

SPOUSE OR ADDITIONAL RESIDENT

Spouse or Additional Resident name:	**Date of Birth** *(MM/DD/YYYY)*

Address

City	**State**	**ZIP code**

Relationship to Applicant:

If the spouse/additional resident named above currently has an Elips 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 _____

lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10874, Clearwater, FL 33757
Elipslife.lumico.com

NOTICE TO APPLICANT

Replacement of Medicare Supplement insurance or Medicare Advantage

Save this notice! It may be important to you in the future.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by Elips Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have thirty (30) days after you received the policy to return it to us, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to applicant from the insurer and agent:

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage 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. In adddition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient drug coverage and I am enrolling in Medicare 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 from Elips Life Insurance Company, 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 requesting that information 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:

Date

Applicant's Signature

Date

lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10874, Clearwater, FL 33757
Elipslife.lumico.com

NOTICE TO APPLICANT

Replacement of Medicare Supplement insurance or Medicare Advantage

Save this notice! It may be important to you in the future.

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by Elips Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have thirty (30) days after you received the policy to return it to us, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

Statement to applicant from the insurer and agent:

I have reviewed your current health insurance coverage. To the best of my knowledge, the replacement of insurance involved in this transaction does not duplicate coverage 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. In adddition, the replacement coverage contains benefits that are clearly and substantially greater than your current benefits for the following reasons:

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient drug coverage and I am enrolling in Medicare 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 from Elips Life Insurance Company, 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 requesting that information 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:

Date

Applicant's Signature

Date

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

California Guaranteed Issue Checklist	Plans Available for Policy Effective dates on or after 1/1/2020 (if offered)
☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and either of the following applies: (a) The plan terminates or ceases to provide all of those supplemental benefits to the individual. This right does not apply if terminating health plan provided primary benefits or if the employee stopped paying their premiums. (b) The employer no longer provides the individual with insurance that covers all of the payment for the 20% coinsurance. ***Voluntarily terminating employer group coverage is **not** a Guaranteed Issue trigger.* ***Acceptable Proof:*** A 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 Program of All-Inclusive Care for the Elderly (PACE), 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. The Medicare Advantage plan in which the individual is enrolled reduces any of its benefits or increases the amount of cost-sharing or premium or discontinues for other than good cause relating to the quality of care under the plan, a provider who is currently furnishing services to the individual. An individual is eligible only for a Medicare Supplement policy issued by the same company through which the individual is enrolled at the time the reduction, increase or discontinuance occurs. If no MedSup policy is available from the same issuer, the subsidiary of the issuer's parent company, or a network that contracts with the parent company of the issuer, the person is eligible for a MedSup policy issued any issuer, if the MedAdvantage plan in which the person is enrolled does any of the following: (a) increases premium by 15% or more, (b) increases copayments by 15% or more, (c) reduces any of the benefits, (d) discontinues, for other than good cause relating to quality of care, its relationship or contact under the plan with a provider who is currently furnishing services to the person. ***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 copy of the personalized letter or documentation of the plan from the Medicare Advantage Company indicating a reduction in benefits or an increase of cost-sharing or premium.	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 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 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, provide a copy of the ID card.)	A, B, D, G, High Ded. G, K or L (if 'Newly Eligible')
☐ Enrolled under a Medicare Supplement policy that covers outpatient prescription drugs enrolls in a Medicare Part D plan during the initial enrollment period terminates enrollment in the Medicare Supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for a policy. ***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 proof of enrollment in a Medicare Part D plan that includes the effective date of the plan (a copy of the application is not acceptable proof).	A, B, C, F, High Ded F, K or L (if **NOT** 'Newly Eligible')
☐ Enrolled in Medicare Part B and notified that because of an increase in the individual's income or assets, he or she meets one of the following requirements: (a) He or she is no longer eligible for Medi-Cal (California Medicaid) benefits. (b) He or she is only eligible for Medi-Cal benefits with a share of cost and certifies at the time of application that he or she has not met the share of cost. ***Acceptable Proof:*** A copy of the personalize letter from Medi-Cal reflecting that the applicant is no longer eligible or only eligible for benefits with a share of cost ***and*** the date change in Medi-Cal benefits has or will take effect.	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)
☐ Enrolled in a Medigap plan and moved out of the area serviced by that plan. In this situation, the applicant has 6 months from the date notified that coverage will be or has ended to enroll in a Medigap plan. ***Acceptable Proof:*** A copy of the personalize letter from Medigap plan reflecting that the applicant no longer resides in a service area ***and*** the date that coverage has or will be ending.	
☐ Enrolled in Military Health Coverage and the coverage ends due to a base closure, a base no longer offering health care services, the applicant moves away from a military base, or the applicant loses access to health care services at a military base. In this situation, the applicant has 6 months from the date notified that coverage will be or has ended to enroll in a Military Health coverage plan. ***Acceptable Proof:*** A copy of the personalize letter from Military Health Coverage plan reflecting the reason coverage is ending ***and*** the date that the coverage has or will be ending.	

☐ Enrolled under an employee welfare benefit or retirement plan and coverage terminates or become no longer eligible due to divorce or death of a spouse or family member. In this situation, the applicant has 6 months from the date notified that coverage will be or has ended to enroll in a Medigap plan. ***Voluntarily terminating employer group coverage is **not** a Guaranteed Issue trigger.* ***Acceptable Proof:*** A 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.)***	
☐ Upon first becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months. ***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)

☐ Beginning on a person's birthday and lasting 60 days or more, a person may purchase any Medicare Supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.

Current Plan (incl. 1990 Standardized Plan)	Equal to (2010 Standardized Plan)	Lesser Benefits (only plans offered by Elips Life)
A	A	None
B	B*	A
C	C*	A, N
D	D*	A, N
E	D*	A, N
F	F	A, G, High Deductible G, N
High Deductible F	High Deductible F*	High Deductible G
G	G	A, High Deductible G, N
High Deductible G	High Deductible G	None
H	D*	A, N
I	G	A, High Deductible G, N
J	F	A, G, High Deductible G, N
High Deductible J	High Deductible F*	High Deductible G
K	K*	A
L	L*	A
M	M*	A
N	N	A

*Plans not offered by Elips Life

Acceptable Proof:
The current carrier policy schedule page containing the policyholder name, plan and policy effective date. If the current plan schedule page is more than 2 years ago, we will also need proof showing the current paid to date of the policy.

Definition of Newly Eligible:

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

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

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

Lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Admin: P.O. Box 10875, Clearwater, FL 33757
Phone: 1-855-774-4491 **Fax:** 1-816-701-2549
[Elipslife.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 Elips 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 Elips 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 I – Payment 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
- ☐ 2nd 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 between the 1st and 28th: _____

(If this date falls on a weekend or holiday, deduction will be on the ***next business*** day.)

SECTION II – Payment options and account information

Account type: ☐ Checking ☐ Savings

_____ _____
Accountholder signature Date

ATTACH VOID CHECK HERE

or complete information below

Accountholders Name: _____

Branch/Bank Name: _____

Routing Number: _____

Account Number: _____

lumico
medigap solutions
Underwritten by
Elips Life Insurance Company

Elips Life Insurance Company
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10875, Clearwater, FL 33757
Elipslife.lumico.com

ELI-MS-RELEASE-2021-001

AUTHORIZATION FOR RELEASE OF PERSONAL AND MEDICAL INFORMATION

I authorize any:

physician	health care professional
hospital	clinic
pharmacy	laboratory
pharmacy benefit manager	medical facility
health information exchange	governmental agency
health plan	any insurance company or any other entity that has any diagnosis whether obtained through the processing and underwriting of applications, the handling of claims, or otherwise
health insurance plan	
health care provider or health care facility	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 Elips Life Insurance Company or its reinsurers, employees, or representatives ("elipsLife"). elipsLife is authorized to obtain my medical records, including records arising from insurance claims, from any of its affiliates that may have such records. 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.

elipsLife 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. elipsLife 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 thirty (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 elipsLife at *P.O. Box 10875, Clearwater, FL 33757-8875.* elipsLife 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