**Underwritten by**
**Tier One Insurance Company**

Home Office: 1932 Wynnton Road, Columbus, GA 31999
Administrative Office: 1021 Reams Fleming Blvd., Franklin, TN 37064
Telephone Number: 1-833-504-0336 Website: www.Aflac.com

# Application

## Medicare Supplement Insurance

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## California

# Application for Medicare Supplement Insurance

- If only one applicant, just complete Applicant A information.
- Complete all required sections of the application. Any incomplete or missing information could result in delay or closure of your application.

## Section 1a. Applicant A Information

**Applicant A name** *(as appears on Medicare card*)* **Phone**

**Residential address** **Apt/suite number**

**City** **State** **Zip**

**Mailing address** *(if different than residential address)* **Apt/suite number**

**City** **State** **Zip**

**E-mail** **Social Security Number**

**Birth date** *(mm/dd/yyyy)* **Age** ☐ **Male** ☐ **Female**

**Are you a legal resident of the United States?** ☐ Yes ☐ No

**Medicare card number*** **Effective date: Medicare Part A** **Medicare Part B**

**Please provide complete Medicare number and a copy of card if possible.*
*If applicant has not received a Medicare card yet, leave blank.*

## Section 1b. Applicant B Information

**Applicant B name** *(as appears on Medicare card*)* **Phone**

**Residential address** **Apt/suite number**

**City** **State** **Zip**

**Mailing address** *(if different than residential address)* **Apt/suite number**

**City** **State** **Zip**

**E-mail** **Social Security Number**

**Birth date** *(mm/dd/yyyy)* **Age** ☐ **Male** ☐ **Female**

**Are you a legal resident of the United States?** ☐ Yes ☐ No

**Medicare card number*** **Effective date: Medicare Part A** **Medicare Part B**

## Section 2a. Household Premium Discount Information

### Household Premium Discount Eligibility Information

You may qualify for a Medicare Supplement household discount with Tier One Insurance Company if (1) you reside with your spouse (including civil union/domestic partner), or (2) you have been living with a family member who is age 50 or older for the last twelve months.

(For the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence.)

If you are eligible based on the above requirements, the discount will be 10 percent lower than the individual rates and will apply as long as these requirements are met.

**Applicant(s) meet(s) these eligibility requirements** ☐ Yes ☐ No

*Upon verification of eligibility and approval of your application, you will qualify for the discount.*

If you answered Yes to the question above, please fill out the following information about the household resident, unless both applicants are applying for coverage on this application:

| **Name** | **Policy number (if applicable)** | **Relationship to Applicant** |
|---|---|---|
| | | |

Mail policy(ies) to: ☐ Applicant(s) ☐ Agent

## Section 2b. Plan and Premium Information – Applicant A

### Payment Modes

You have a choice among several payment options or modes for paying your premium: annual, semi-annual, quarterly and monthly electronic funds transfer (EFT). Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy. PLEASE NOTE: Regardless of premium mode selected, only one month's worth of premium is due with the application.

**Applicant A Plan selected*** **Requested Medicare Supplement effective date** *(mm/dd/yyyy)*

☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

**Plan F available to those first eligible before 01/01/2020*

| **Modal premium** | **Modal premium with discount** | **Total initial premium collected/draft** |
|---|---|---|
| **$** | **$** | **$** |

**Initial Premium**

☐ Draft initial premium upon policy approval ☐ Draft initial premium on the policy effective date

**Subsequent draft date**** **Payment mode**

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

**Initial Premium**

☐ Check ☐ EFT ☐ List Bill Billing file identifier:

*If applying for household discount, provide the discounted and non-discounted premium amounts.*
**Plans A, G and N are available to all applicants. Plan F is available **ONLY** to those first eligible for Medicare before 1/1/2020.*
*** Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.*

## Section 2b. Plan and Premium Information – Applicant B

**Applicant B Plan selected** **Requested Medicare Supplement effective date** *(mm/dd/yyyy)*

☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan N

**Plan F available to those first eligible before 01/01/2020*

| **Modal premium** | **Modal premium with discount** | **Total initial premium collected/draft** |
|---|---|---|
| **$** | **$** | **$** |

**Initial Premium**

☐ Draft initial premium upon policy approval ☐ Draft initial premium on the policy effective date

**Subsequent draft date**** **Payment mode**

☐ Annually ☐ Quarterly ☐ Semi-annually ☐ Monthly EFT

**Initial Premium**

☐ Check ☐ EFT ☐ List Bill Billing file identifier:

## Section 3. Eligibility Questions

| **To the best of your knowledge:** | **Applicant: A** | **B** |
|---|---|---|
| **1. Did you turn age 65 in the last 6 months?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **i.** Did you enroll in Medicare Part B in the last 6 months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **ii.** If yes, what is the effective date? *(mm/dd/yyyy)* | | |
| **A** **Applicant A** effective date | **B** **Applicant B** effective date | |
| **iii.** If you are applying for coverage effective under age 65, do you have End Stage Renal Disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |

## Section 3. Eligibility Questions *continued*

*NOTE: If you have a share of cost under the Medi-Cal program please **answer no** to question 2.*

| | Applicant: A | Applicant: B |
|---|---|---|
| **2. Are you covered for medical assistance through the state Medi-Cal program?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **i.** If yes, will Medi-Cal pay your premiums for this Medicare Supplement policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **ii.** Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**3. If 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), fill in your start and end dates below. If you are still covered under this plan, leave "End date" blank.**

**A** Start date _____ End date _____ **B** Start date _____ End date _____

| | | |
|---|---|---|
| **i.** 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 | ☐ Yes ☐ No |
| **ii.** Was this your first time in this type of Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **iii.** Did you drop a Medicare Supplement policy to enroll in the Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **4. Do you have another Medicare Supplement policy in force?** | ☐ Yes ☐ No | ☐ Yes ☐ No |

**i.** If yes, for Applicant A, with what company, and what plan do you have?

**A** Company _____ Plan _____

If yes, for Applicant B, with what company, and what plan do you have?

**B** Company _____ Plan _____

| | | |
|---|---|---|
| **ii.** If so, do you intend to replace your current Medicare Supplement policy with this policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **iii.** Are you replacing another Medicare Supplement policy from Tier One Insurance Company? | ☐ Yes ☐ No | ☐ Yes ☐ No |

If yes, list the policy number:

**A** **Applicant A** _____ **B** **Applicant B** _____

*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.*

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

**i.** If yes, with what company and what kind of policy do you have?

**A** Company _____ Policy _____ **B** Company _____ Policy _____

**ii.** What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.)

**A** Start date _____ End date _____ **B** Start date _____ End date _____

**---------- For agent use only ----------**

Check if application is for:

| | | | |
|---|---|---|---|
| **Applicant A** | ☐ Open Enrollment | ☐ Guaranteed Issue | ☐ Underwritten |
| **Applicant B** | ☐ Open Enrollment | ☐ Guaranteed Issue | ☐ Underwritten |

## Section 4: Health Questions

*Answer these questions **only if you're applying for underwritten coverage**.*
***Do not answer these questions for an Open Enrollment or Guaranteed Issue application.***
***(Please see section 8 regarding Open Enrollment or Guarantee issue.)***
*If any health questions are answered "yes" in section 4, the applicant(s) will not qualify for this insurance with us.*

| | Applicant: A | Applicant: B |
|---|---|---|
| **1. Are you dependent on a wheelchair or any motorized mobility device?** | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **2. Do any of the following apply to you?** | | |
| Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?** | | |
| **A.** congestive heart failure, unoperated aneurysm, defibrillator | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **B.** leukemia, lymphoma, multiple myeloma, cirrhosis | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **C.** Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **D.** chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **E.** any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **F.** Acquired Immune Deficiency Syndrome (AIDS), 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.*** | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **4. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?** | | |
| **A.** that requires use of insulin | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **B.** with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **C.** with history of heart attack or stroke (at any time) | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **D.** treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?** | | |
| **A.** alcoholism, drug abuse | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **B.** cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **C.** internal cancer, melanoma, Hodgkin's Disease | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **D.** hepatitis, disorder of the pancreas | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |

## Section 4: Health Questions *continued*

| | Applicant: A | Applicant: B |
|---|---|---|
| **6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?** | | |
| **A.** enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **B.** myasthenia gravis, systemic lupus or connective tissue disorder | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **C.** osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **D.** any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **E.** any lung or respiratory disorder and currently use tobacco products | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?** | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?** | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?** | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **10. Within the past 12 months, do any of the following apply to you?** | | |
| **A.** had a pacemaker implanted | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **B.** had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **C.** had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **D.** had a seizure | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **11. Was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic?** *Systolic is the upper number and diastolic is the bottom number of the blood pressure reading.* | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |
| **12. Have you used any form of tobacco in the past 12 months? (Including vaping & e-cigarettes)** *Answering "yes" to question 12 will not disqualify you for this insurance.* | ☐ Yes ☐ No ☐ Unsure | ☐ Yes ☐ No ☐ Unsure |

**Applicant A**
**Height** (feet & inches) **Weight** (pounds)

**Applicant B**
**Height** (feet & inches) **Weights** (pounds)

## Section 5: Health History – Applicant A

*If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section.** **(Please see section 8 regarding Open Enrollment or Guarantee issue.)***

**Applicant A**

**Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide diagnosis. If unsure how to respond or cannot recall, please indicate as such:**

**Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide diagnosis. If unsure how to respond or cannot recall, please indicate as such:**

**List the name of any medications you are taking and the diagnosis, if known. If unsure how to respond or cannot recall, please indicate as such:**

## Section 5: Health History – Applicant B

**Applicant B**

**Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide diagnosis. If unsure how to respond or cannot recall, please indicate as such:**

**Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide diagnosis. If unsure how to respond or cannot recall, please indicate as such:**

**List the name of any medications you are taking and the diagnosis, if known. If unsure how to respond or cannot recall, please indicate as such:**

*Use an additional sheet of paper if needed for explanation.*

*If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section.***

## Section 6: Physician Information – Applicant A

**Applicant A primary physician** | **Phone**

**Physician's office name**

**City** | **State**

**Specialist seen in the past 24 months** | **Specialty**

**Reason for seeing** (diagnosis)

**Specialist seen in the past 24 months** | **Specialty**

**Reason for seeing** (diagnosis)

**Specialist seen in the past 24 months** | **Specialty**

**Reason for seeing** (diagnosis)

**Have you seen any additional physicians other than those listed above in the past 24 months?** ☐ Yes ☐ No

## Section 6: Physician Information – Applicant B

**Applicant B primary physician** | **Phone**

**Physician's office name**

**City** | **State**

**Specialist seen in the past 24 months** | **Specialty**

**Reason for seeing** (diagnosis)

**Specialist seen in the past 24 months** | **Specialty**

**Reason for seeing** (diagnosis)

**Specialist seen in the past 24 months** | **Specialty**

**Reason for seeing** (diagnosis)

**Have you seen any additional physicians other than those listed above in the past 24 months?** ☐ Yes ☐ No

## Section 7. Important Statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
4. 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.
5. If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of 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, 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.

## Section 8 – Guarantee Issue and Open Enrollment Eligibility

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

☐ Enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare; and the plan terminates, or the plan ceases to provide all such supplemental health benefits or the Medicare Part B 20% coinsurance for services to the individual (eligible for Plans A, G or N); or

☐ Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) 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 within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual (eligible for Plans A, G or N); or

☐ 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 (eligible for Plans A, G or N); 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 specific circumstances permit discontinuance 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 (eligible for Plans A, G or N); or

☐ Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency, substantial violation of a material policy provision, or material misrepresentation (eligible for Plans A, G or N); or

☐ 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 (eligible for the same Plan you terminated with us, or, if that Plan is no longer available, Plans A, G or N); or

☐ 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 (eligible for all plans available from us); or

☐ Enrolled in a Medicare Part D Plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy (eligible for Plans A, G or N).

**Documentation of these events must be submitted with this Application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.**
The following are requirements for individuals who are eligible for open enrollment:

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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.

☐ 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 9. Producer Compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by simply taking your insurance application, collecting your initial premiums and delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase, or the specific options included with your policy. The agent can receive compensation by:

1. Commissions when a policy is purchased or renewed
2. Fees for marketing and administrative services
3. Educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses.

We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

## Section 10. Applicant(s) Agreement

This agreement is to acknowledge that I am applying for an insurance policy from Tier One Insurance Company that will be issued based on my answers to the questions on this application. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application. I acknowledge that I have received an outline of coverage for the policy that I applied for, along with a copy of Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant.

I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The Company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the Company's home office, and made a part of the contract of insurance. An Officer of the Company is the only one who can make, modify or discharge contracts or waive any of the Company's rights or requirements; and any modifications must be documented in writing.

I also understand that I do not have coverage until this application is approved, the first premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application

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 Web site (www.insurance.ca.gov).

***I understand that if any answers on this application are incorrect, incomplete or untrue, Tier One Insurance Company has the right to adjust my premium or cancel the policy.***

**Applicant A signature** **Date signed**

**X**

**Applicant B signature** **Date signed**

**X**

*For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in state prison.*

*Complete this section **if you are requesting electronic funds transfer** (EFT) for premium payment. Include a voided check with the application.*

## Section 11. Account Information – Applicant A

**Applicant A name**

**Account Owner name** *(if different than proposed insured's)*

**Account Owner relationship to proposed insured**

☐ Business owned by proposed insured ☐ Living trust ☐ Employer

☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

**Financial institution name**

**Account type**

☐ Checking ☐ Savings

**Routing number**

**Account number**

## Section 11. Account Information – Applicant B

**Applicant B name**

**Account Owner name** *(if different than proposed insured's)*

**Account Owner relationship to proposed insured**

☐ Business owned by proposed insured ☐ Living trust ☐ Employer

☐ Power of Attorney ☐ Conservator/guardian ☐ Family member; please specify:

**Financial institution name**

**Account type**

☐ Checking ☐ Savings

**Routing number**

**Account number**

## Section 12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

***Signature only required if** the account owner is different than the proposed insured.*

**Account owner signature – Applicant A**

**Date signed**

**X**

**Account owner signature – Applicant B**

**Date signed**

**X**

## Section 13. Agent Information

**Please list any other medical or health insurance policies sold to Applicant A.**

**1. List policies sold which are still in force**

**2. List policies sold in the past 5 years which are no longer in force**

**Please list any other medical or health insurance policies sold to Applicant B.**

**1. List policies sold which are still in force**

**2. List policies sold in the past 5 years which are no longer in force**

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant(s).
2. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation.
3. If any material fact is stated to be true, and yet I know is false, in addition to any applicable penalties or remedies available under current law, by subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.
4. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
5. I have provided an outline of coverage for the policy(ies) applied for and A Guide to Health Insurance for People with Medicare to applicant(s) prior to completing the application.

***All information must be completed.*** *The writing number reflects where commissions will be paid.*

**Agent name** *(printed)*

**Agent signature**

**X**

**Writing number** *(agent or company)*

**State license ID number** *(for FL only)*

**Phone**

**Email**

## Section 14. Agent request to split commissions

If this application results in an issued policy through Tier One Insurance Company (TOIC), the agents listed below have agreed to split the commissions earned on the policy.

1. Both agents must be properly licensed and appointed with TOIC in the policy's state of issue.
2. Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
3. The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
4. Calculation of each agent's commissions are based on their respective TOIC commission schedule.

**Writing agent name** *(printed)*

**Percentage**

%

**Secondary agent** *(printed)*

**Writing number**

**Percentage**

%

**Writing agent signature**

**X**

*This section must be completed with this application in order to split commissions.*
*By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.*

**Underwritten by Tier One Insurance Company**
Home Office: 1932 Wynnton Road, Columbus, GA 31999
Administrative Office: 1021 Reams Fleming Blvd., Franklin, TN 37064
Telephone Number: 1-833-504-0336 Website: www.Aflac.com

# Applicant Receipt

*Thank you!*

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Tier One Insurance Company.
- **DO NOT** make any check payable to the agent and **DO NOT** leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

| | |
|---|---|
| **Applicant A** *(printed)* | **Date of application** |
| **Initial payment collected** *(if applicable)* | **Payment Type** ☐ Check ☐ Money order |
| **EFT draft amount** **$** | **EFT draft date** |
| **Applicant B** *(printed)* | **Date of application** |
| **Initial payment collected** *(if applicable)* | **Payment Type** ☐ Check ☐ Money order |
| **EFT draft amount** **$** | **EFT draft date** |

This acknowledges receipt of your application for Tier One Insurance Company Medicare Supplement insurance policy.

| | |
|---|---|
| **Agent name** *(printed)* | **Agent signature** **X** |
| **Phone** | **Email** |

***Thank you for choosing Aflac!***