Elips Life Insurance Company
State of Domicile: Missouri
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10875, 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

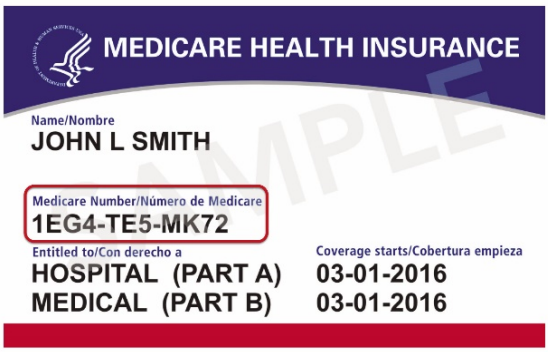
City	State	ZIP code

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

Household premium discount

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

Modal Premium	Policy fee	Premium collected
$	$	$

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

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

Please answer ALL of the following questions.

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	☐ Yes	☐ No
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?	☐ Yes	☐ No
4.	Are you: - currently hospitalized, - in a nursing home or assisted living facility, - or have you been hospitalized three or more times in the past two years?	☐ Yes	☐ No
5.	Are you currently receiving any: - occupational, speech, or physical therapy, or - services from a home healthcare agency?	☐ Yes	☐ No
6.	Within the past ten years, 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?	☐ Yes	☐ No
7.	Within the past ten years, 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?	☐ 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, - kidney insufficiency, or - renal failure requiring dialysis?	☐ Yes	☐ No
d)	- Emphysema, - chronic obstructive pulmonary disease (COPD), - 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

SECTION IV – Health questions *(continued)*

g) Chronic hepatitis or cirrhosis of the liver?	☐ Yes	☐ No
h) Cardiac defibrillator implantation?	☐ Yes	☐ No
8. Have you had any of the following in the last two (2) years:		
a) - Heart attack, - cardiac angioplasty, or - bypass surgery, - 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
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?	☐ 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
10. Within the past ten years have you had diabetes or been prescribed or advised by a medical professional to take medication to reduce/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*'.	☐ Yes	☐ No
a) Within the past ten years, have you been 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, - transient ischemic attack (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 further review.

11. Are you currently receiving, or have you been advised to receive injections in a physician's office?	☐ Yes	☐ No
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?	☐ Yes	☐ No
b) - Peripheral artery disease, - peripheral vascular disease, or - peripheral venous thrombotic disease, - carotid artery disease?	☐ Yes	☐ No
c) - Degenerative bone disease, - spinal stenosis? - rheumatoid arthritis, or	☐ Yes	☐ No
d) Any mental or nervous disorder requiring treatment by a psychiatrist?	☐ Yes	☐ No

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 age 65 in the last six months?	☐ Yes	☐ No
b) Did you enroll in Medicare Part B in the last six months?	☐ Yes	☐ No
If *YES*, please indicate your effective date *(From Medicare Health Insurance card, MM/DD/YYYY)*.		
2. Are you covered for medical assistance through the state Medicaid program? *NOTE: If you are participating in a "*Spend-Down Program*" and have not met your "*Share of Cost*", please answer* NO *to this question.*	☐ Yes	☐ No
If *YES*, please answer questions a) and 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 sixty three (63) days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.)	☐ Yes	☐ No
If *YES*, please answer questions a) to g) 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
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)*	

SECTION VII – Replacement questions *(continued)*

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,* please answer questions a) to 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 your other in force policy's termination date *(MM/DD/YYYY).*		
d) Have you received a copy of the replacement notice?	☐ 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 non-Medicare supplement plan.)	☐ Yes	☐ No

If *YES,* please answer questions a) to c) 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) Reason for termination/disenrollment?	
c) Planned date of termination/disenrollment? *(MM/DD/YYYY)*	

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 – 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 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.

  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

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 acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation and that there are no consequences if consent is withdrawn.

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

SECTION X – Electronic and/or telephonic instructions *(continued)*

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 acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation and that there are no consequences if consent is withdrawn.

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

Note: I acknowledge that I am responsible for notifying the Company in the event that the email address should change and that I have the option to receive written communication in paper form. If the Company receives a return message as undeliverable each time electronic delivery is attempted over two business days, it will be presumed consent has been withdrawn.

SECTION XI – Signature and final acknowledgments

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.**

(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

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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

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 married and residing with my spouse 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 _____

Elips Life Insurance Company
State of Domicile: Missouri
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10875, 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.

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 Elips 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.

☐ 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 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 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

Elips Life Insurance Company
State of Domicile: Missouri
Home: 1450 American Lane, Suite 1100,Schaumburg, IL 60173
Admin: P.O. Box 10875, Clearwater, FL 33757
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Statement to applicant by agent:

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☐ 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 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 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.***

Utah 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 the plan terminates or the plan ceases to provide all such supplemental health benefits to the individual. ***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.)***	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 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. ***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.	
☐ 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.	
☐ The individual is enrolled under medical assistance under Title XIX of the Social Security Act, Medicaid, and is involuntarily terminated outside of requirements of Subsections 8.A.(7)(a) and (b). ***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.	
☐ 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, provide a copy of the ID card.)	

☐ Upon first becoming eligible for benefits under Part A, enrolls in a Medicare Advantage or PACE provider plan and then disenrolls by not 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)

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