

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)	
<input type="checkbox"/> Male <input type="checkbox"/> 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:

MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A) **03-01-2016**
MEDICAL (PART B) **03-01-2016**

ALL PAGES OF THE APPLICATION MUST BE SUBMITTED

SECTION II – Plan and payment information

Plan	Requested policy effective date	
Household premium discount		
<input type="checkbox"/> Yes (please complete the Household Discount form) <input type="checkbox"/> No		
Modal Premium	Policy fee	Premium collected
\$	\$	\$
Payment method (select one):	Payment mode (select one):	
<input type="checkbox"/> Billed (select one):	<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual	
<input type="checkbox"/> Bank draft (select one):	<input type="checkbox"/> Monthly (bank draft only) <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual	

SECTION III – Eligibility questions (please answer all questions)

1. 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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Are you covered under Medicare Part A? 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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you covered under Medicare Part B? 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)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you enrolled in Medicare Part B more than once?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Are you applying during a guaranteed issue period? (If YES, you must attach your proof of eligibility to this application.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)? IF YES, please check the box that applies. <input type="checkbox"/> Disability <input type="checkbox"/> End Stage Renal Disease (ESRD)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 2 to 9 in this section, you are not eligible for coverage.

1. Height (<i>feet and inches</i>):	Weight (<i>pounds</i>):	
2. - 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you: - currently hospitalized, - in a nursing home or assisted living facility, - or have you been hospitalized three or more times in the past two years?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Are you currently receiving any: - occupational, speech, or physical therapy, or - services from a home healthcare agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) - Acquired immune deficiency syndrome (AIDS), - AIDS related complex (ARC), or - human immunodeficiency virus (HIV) infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) - Chronic kidney disease stage 3-5, - kidney insufficiency, or - renal failure requiring dialysis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) - Emphysema, - chronic obstructive pulmonary disease (COPD), - any other chronic pulmonary condition, or - any medical condition requiring the use of oxygen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) - Systemic lupus, - scleroderma, or - myasthenia gravis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) An organ transplant or been advised to have an organ transplant (excluding cornea transplants)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

SECTION IV – Health questions (continued)

g) Chronic hepatitis or cirrhosis of the liver?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Cardiac defibrillator implantation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Vascular angioplasty - implantation of a pacemaker? - endarterectomy, or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) A stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) - Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), - leukemia, - melanoma, - Hodgkin's disease, or - lymphoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Arthritis that restricts mobility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. 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'.		
a) Have you ever required or been advised to take more than fifty (50) units of insulin daily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Do you take three (3) or more medications (oral or injections) to control your blood sugar?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Do you take four (4) or more medications to control your high blood pressure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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,	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.

10. Are you currently receiving, or have you been advised to receive injections in a physician's office?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
11. 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) - Peripheral artery disease, - peripheral vascular disease, or - peripheral venous thrombotic disease, - carotid artery disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) - Degenerative bone disease, - spinal stenosis? - rheumatoid arthritis, or	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Any mental or nervous disorder requiring treatment by a psychiatrist?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 (<i>copy off pharmacy label</i>):	
Date originally prescribed (<i>MM/DD/YYYY</i>):	
Date prescription last filled (<i>MM/DD/YYYY</i>):	
Dosage and frequency:	
Diagnosis/condition:	
Medication name (<i>copy off pharmacy label</i>):	
Date originally prescribed (<i>MM/DD/YYYY</i>):	
Date prescription last filled (<i>MM/DD/YYYY</i>):	
Dosage and frequency:	
Diagnosis/condition:	
Medication name (<i>copy off pharmacy label</i>):	
Date originally prescribed (<i>MM/DD/YYYY</i>):	
Date prescription last filled (<i>MM/DD/YYYY</i>):	
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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Did you enroll in Medicare Part B in the last six months?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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? <i>NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please answer questions a) and b) below.		
a) Will Medicaid pay your premiums for this Medicare supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Do you receive any benefits from Medicaid <i>OTHER THAN</i> payment toward your Medicare Part B premium?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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: <i>If you are still covered under this plan, leave end date blank.</i>
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, have you received a copy of the replacement notice?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Is your former Medicare supplement or Medicare select policy/certificate still available?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Do you have another Medicare supplement or Medicare select insurance policy in force?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Indicate your other in force policy's termination date (MM/DD/YYYY).		
d) Have you received a copy of the replacement notice?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.)	<input type="checkbox"/> Yes	<input type="checkbox"/> 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:
	<i>If you are still covered under this plan, leave end date blank.</i>	
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 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 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

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Agent writing number

Agent's signature

Date

Policy mailing preference:

☐ Mail to Agent

☐ Mail to Applicant

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

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.
- ☐ Change in benefits (Gaining additional benefit(s) but losing some existing benefit(s)).
- ☐ My plan has outpatient drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:

☐ Other (please specify): _____

If, you still wish to terminate your present policy and replace it with new coverage 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

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- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ Change in benefits (Gaining additional benefit(s) but losing some existing benefit(s)).
- ☐ My plan has outpatient drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:

☐ Other (please specify): _____

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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

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