ACE PROPERTY & CASUALTY INSURANCE COMPANY

Home Office: Philadelphia, Pennsylvania
Administration: P.O. Box 10856, Clearwater, Florida 33757-8856

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION A. PROPOSED INSURED INFORMATION	**APPLICATION#**
Applicant Name *(exactly as it appears on your Medicare card)*	
Resident Address	Phone *(with area code)*
City	State, Zip Code
Date of Birth	Age
Male ☐ Female ☐	Social Security No
Medicare Number	
Email Address	
Height	Weight

SECTION B. PLAN AND PREMIUM INFORMATION				
Plan	Requested Policy Effective Date			
Household Premium Discount ☐ No ☐ Yes (please complete the Household Discount Form)				
Premium $				
Premium Collected $	Initial Bank Draft: $			
Payment Mode: Bank Draft ☐	Monthly ☐ (Bank Draft ONLY)	Annual ☐	Semi-Annual ☐	Quarterly ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS	
1. Have you used tobacco in any form, including cigarettes, vapes, nicotine gum or patches, cigars, chewing tobacco, pipes, or eCigarettes in the past twelve (12) months?	Yes ☐ No ☐
2. Are you covered under Medicare Part A?	Yes ☐ No ☐
If NO, what is your future Part A effective date? _____	
If YES, what is your Part A effective date? _____	
3. Are you covered under Medicare Part B?	Yes ☐ No ☐
If NO, what is your future Part B effective date? _____	
If YES, what is your Part B effective date? _____	
Have you enrolled in Medicare Part B more than once?	Yes ☐ No ☐
4. Are you applying during a guaranteed issue or Continuity of Coverage period? (If YES please provide proof of eligibility).	Yes ☐ No ☐
5. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)?	Yes ☐ No ☐
(If YES please check the box that applies. ☐ Disability ☐ End Stage Renal Disease (ESRD)	

SECTION D. HEALTH QUESTIONS

If applying during an Open Enrollment or a Guaranteed Issue or a Continuity of Coverage period, go to **SECTION F**.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1–15, you are not eligible for coverage.

1. Are you currently hospitalized or in a nursing home or assisted living facility; or, are you bedridden or confined to a wheelchair, or require the assistance of motorized mobility aid, or have you had any amputation caused by disease? Yes ☐ No ☐

2. Are you currently receiving any occupational, speech, or physical therapy, or are you currently receiving any services from a home healthcare agency? Yes ☐ No ☐

3. Have you had, been medically diagnosed with, or treated at any time for Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other chronic pulmonary disorders, or any medical condition requiring the use of oxygen? Yes ☐ No ☐

4. Have you had, been medically diagnosed with, or treated at any time for Parkinson's Disease, Arthritis that restricts mobility, Systemic Lupus, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Scleroderma, Chronic kidney disease (stage 3-5), Chronic Hepatitis, Cirrhosis of the liver, or renal failure requiring dialysis? Yes ☐ No ☐

5. Have you been diagnosed with Alzheimer's Disease, Dementia, Muscular Dystrophy, or any other cognitive disorder? Yes ☐ No ☐

6. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes ☐ No ☐

   Answer this question 'NO' if you have tested positive for HIV but have not developed either symptoms or the disease AIDS.

7. If you have diabetes or take prescription medication to control your blood sugar, have you been medically diagnosed with or treated for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney failure, kidney disease, stroke, transient ischemic attack (TIA), congestive heart failure, or any heart disorder? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes ☐ No ☐

8. If you have diabetes or take prescription medication to control your blood sugar, do you take three (3) or more medications (oral or injections) to control your blood sugar? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes ☐ No ☐

9. If you have diabetes or take prescription medication to control your blood sugar, do you take four (4) or more medications to control your high blood pressure? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes ☐ No ☐

10. Have you ever had a medical professional advise you to take more than 50 units of insulin daily or have you ever required more than 50 units of insulin daily for diabetes or to control your blood sugar? Yes ☐ No ☐

SECTION D. HEALTH QUESTIONS (continued)

11. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for internal cancer (examples include but are not limited to liver, breast or lung cancer, etc.), malignant melanoma, lymphoma, leukemia, Hodgkin's disease, alcoholism or drug abuse, or have you been advised to have a joint replacement? Yes ☐ No ☐

12. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for heart attack, cardiac angioplasty, implantation of a pacemaker, bypass surgery, stent placement or replacement, vascular angioplasty, endarterectomy, stroke or transient ischemic attack (TIA)? Yes ☐ No ☐

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

14. Have you been hospital confined three (3) or more times in the last two (2) years? Yes ☐ No ☐

15. Have you had, been medically diagnosed with, or treated at any time for an organ transplant, been advised by a physician to have an organ transplant (excluding cornea transplants) or had a cardiac defibrillator implanted? Yes ☐ No ☐

If you answer YES to any of the following health questions 16-19, you may be eligible for coverage.

16. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for angina, heart attack, heart disease, heart valve disease, coronary artery disease, aortic or cardiac aneurysm, cardiomyopathy, carotid artery disease (not including high blood pressure), congestive heart failure, atrial fibrillation, peripheral vascular disease, peripheral venous thrombotic disease, enlarged heart, or other heart rhythm disorder? Yes ☐ No ☐

17. Within the past two (2) years have you been treated for degenerative bone disease, rheumatoid arthritis, or spinal stenosis? Yes ☐ No ☐

18. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for a mental or nervous disorder requiring treatment by a psychiatrist? Yes ☐ No ☐

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

(Please explain any yes answers to questions 16 – 19 below)

SECTION E. MEDICATION HISTORY

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

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

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

SECTION F. REPLACEMENT QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐

   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐

   (c) If YES, what is the effective date?

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.)

   If YES,

   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? If yes, please describe. Yes ☐ No ☐

   .....

3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 90 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" blank. If your previous coverage before this Medicare plan was a different Medicare plan of the same type, your "START" date is the day you began your **first** plan of this type.

   START ..... END .....

   (b) If you have been covered by more than one Medicare plan of this type, have you been covered continuously by these plans, with no break in coverage and no period of original Medicare (Part A or B) between the first plan and your current plan? Yes ☐ No ☐

   (c) 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 ☐

   (d) Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes ☐ No ☐

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

   (b) If so, with what company, and what plan do you have?

   .....

   (c) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 90 days? (For example, an employer, union, or individual plan.) Yes ☐ No ☐

   (a) If so, with what company and what kind of policy?

   .....

   .....

   .....

   .....

   (b) What are your dates of coverage under the other policy?

   START ..... END .....

   (If you are still covered under the other policy, leave "END" blank)

This section to be completed only by an agent, if applicable.

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

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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

MEDICARE SUPPLEMENT OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Sections D and E on pages 2 through 4 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

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:

a. The individual is eligible for Medicare Part B and is enrolled under an employee welfare benefit plan and the plan terminates, or the plan ceases to provide some or all benefits that supplement the benefits under Medicare to the individual, or the plan ceases to provide health benefits to the individual because the individual leaves the plan; or

b. 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, a material misrepresentation was made to the individual, or the individual voluntarily disenrolled after receiving notice from the organization or plan that the organization or plan will be terminated or discontinued in the area where they reside; or

c. 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; or

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

e. 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 36 months of enrollment; or

f. Upon first becoming enrolled for benefits under Part B, enrolled in a Medicare Advantage plan under part C or Medicare, or with a PACE provider under Section 1894 of the Social Security Act, and then disenrolls from the plan by not later than thirty-six (36) months after the effective date of enrollment; or

g. The individual is eligible for Medicare Part B and is enrolled in an individual health plan and the individual's coverage under the individual health plan terminates or is expected to terminate for any reason except for fraud or nonpayment of premium. An individual whose coverage has been terminated for nonpayment of premium or who has received a notice of termination for nonpayment of premium is an eligible person if he or she provides proof that the outstanding premium debt has been paid, that he or she has entered into a payment agreement with the issuer of the individual plan, or that he or she has sought or received bankruptcy protection with respect to the debt; or

h. The individual is eligible for Medicare Part B and is enrolled in Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of immunization benefits under Section 1928, and enrollment in Medicaid ceases because the individual is no longer eligible.

Documentation of these events must be submitted with the application. You must apply within 90 days of the date of termination of previous coverage in order to qualify as an eligible person. You do not need more than one Medicare supplement policy.

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. 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).

ELECTRONIC INSTRUCTIONS

Authorization is requested by ACE Property & Casualty Insurance Company to act on electronic instructions from the applicant, and to electronically deliver statements and other documents to 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 ACE Property & Casualty Insurance Company to act on electronic instructions, and to electronically deliver statements and other documents 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.

☐ I DO NOT authorize ACE Property & Casualty Insurance Company to act on electronic instructions, and to electronically deliver statements and other documents.

Note: I acknowledge that I am responsible for notifying ACE Property & Casualty Insurance Company in the event that the email address should change and that I have the option to receive written communication in paper form.

AGENT CERTIFICATION

I, the authorized agent, have on the date of application recorded the information as given to me by the Applicant, and certify that during an interview with the proposed applicant, I have truly and accurately recorded in the application the information supplied by the applicant.

Signed at:

State	Writing Number	Signature of Agent	Signature Date

Policy Mailing Preference: ☐ Mail to Insured ☐ Mail to Licensed Agent

DESIGNATED ASSIGNEE – PROTECTION AGAINST UNINTENDED LAPSE

Name and Address of Person Other Than Applicant Who Would Receive Notice of Lapse. Designation of this person does not constitute acceptance of any liability by this person for services provided to you.

Full Name of Designee: Telephone Number:

Address:

WAIVER OF DESIGNATED ASSIGNEE: I understand that I have the right to designate at least one person other than myself to receive notice of lapse of my Medicare Supplement policy for nonpayment of premium. I elect **NOT** to designate a person to receive this notice.

Signature of Applicant Date

AUTHORIZATION AND CERTIFICATION

It is very important that you review your application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me ("protected health information") to the Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, any consumer reporting agency such as MIB, LLC, and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes. This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.

Further, protected health information includes genetic information and genetic test results, and I specifically authorize my providers to disclose such information and results to the Company, subject to the terms and conditions of this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives, and to any consumer reporting agency such as MIB, LLC.

I understand that this protected health information is to be used or disclosed under this authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Company at their Medicare Supplement Administrative Office: P.O. Box 10856, Clearwater, Florida 33757-8856. I understand that a revocation is not effective to the extent that any person or entity has already relied on this authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand and acknowledge that I or any authorized representative will receive or have received a copy of this authorization. A photocopy of this authorization will be treated in the same manner as the original.

AUTHORIZATION AND CERTIFICATION (continued)

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

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	Signature Date