FAMILY LIFE INSURANCE COMPANY

Home Office: Houston, TX **Medicare Supplement Administrative Office: P. O. Box 924408, Houston, TX 77292-4408**

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICATION #:

APPLICANT	**RESIDENCE ADDRESS**
Last *First* *MI*	*Street:*
Check the Medicare Supplement Plan You Prefer: ☐ **Standardized Plan A** ☐ **Standardized Plan F** ☐ **Standardized Plan B** ☐ **Standardized Plan G** ☐ **Standardized Plan C** ☐ **Standardized Plan M** ☐ **Standardized Plan D** ☐ **Standardized Plan N**	*City:* *State:* *Zip Code:*

MEDICARE INFORMATION	**MAILING ADDRESS**
Date first enrolled in Medicare Part B:_____	*Street:*
Medicare Claim Number: _____ ***(Please include Alpha Character)***	*City:* *State:* *Zip Code:*

AGE	**DATE OF BIRTH**			**SEX**
	Month	*Day*	*Year*	☐ Male ☐ Female
SOCIAL SECURITY NUMBER				

AREA CODE	**TELEPHONE NUMBER**
HEIGHT	**WEIGHT**
Feet **Inches**	**Lbs.**

Effective Date:	***Special Requests:***

SPOUSE	**Spouse's Medicare Claim Number:**
Last *First* *MI*	

UNDERWRITING RISK CLASSIFICATION QUESTION	**MODAL PREMIUM:** $ _____
*Have you used any form of tobacco in the past five years? ☐ Yes ☐ No ****(This question only needs to be answered if applying for the non smoker discount)***	**SPOUSAL DISCOUNT:** $ _____ **(IF APPLICABLE)** **POLICY FEE:** $ 25.00 **TOTAL INITIAL PREMIUM:** $ _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

☐ Bank Draft ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE *NOT REQUIRED* TO ANSWER HEALTH QUESTIONS 1-14 IF YOU ARE IN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE FOUR FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-14, YOU MAY NOT BE ELIGIBLE FOR COVERAGE.

1.	Are you bedridden or confined to a wheelchair or require the assistance of a motorized mobility aid; or in the past two years have you suffered two or more falls within a six month period?	☐ Yes	☐ No
2.	Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?	☐ Yes	☐ No
3.	In the past two years, has surgery or tests been advised by a physician but not performed?	☐ Yes	☐ No
4.	Is surgery anticipated in the next twelve months?	☐ Yes	☐ No

PART I – HEALTH QUESTIONS CONTINUED

5. Within the past two years have you had an amputation caused by disease? ☐ Yes ☐ No
6. Do you have now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for any of the following:
   a. Parkinson's Disease, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Muscular Dystrophy, Alzheimer's Disease, or any other cognitive disorder? ☐ Yes ☐ No
   b. Diabetes that has required more than 50 units of insulin daily or more than two medications (insulin or oral), Chronic Kidney Disease or Insufficiency, or Renal Failure requiring dialysis? ☐ Yes ☐ No
   c. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary condition? ☐ Yes ☐ No
   d. Internal Cancer, Leukemia, Malignant Melanoma, Hodgkin's Disease, or Lymphoma? ☐ Yes ☐ No
   e. Congestive Heart Failure (CHF), heart attack, Coronary or Carotid Artery Disease, Peripheral Vascular Disease, Stroke or Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
7. Within the past two years have you had atrial fibrillation, heart valve surgery, cardiac pacemaker replaced or implanted, or been treated with a heart defibrillating device? ☐ Yes ☐ No
8. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Cirrhosis of the Liver, Hepatitis, Alcohol or Drug Abuse, or Systemic Lupus? ☐ Yes ☐ No
9. Have you had an organ transplant or been advised to have an organ transplant? ☐ Yes ☐ No
10. Are you currently using the services of a home health care agency? ☐ Yes ☐ No
11. Do you require or receive any assistance with any of your activities of daily living such as transferring, bathing, toileting, eating, dressing, or continence? ☐ Yes ☐ No
12. Within the past two years have you had, or been treated for, or has treatment been recommended by a physician for Disabling Arthritis, Paget's Disease of the bone, or Rheumatoid Arthritis? ☐ Yes ☐ No
13. Do you now, or during the past five years have you received medical treatment, or been advised to have treatment, surgery or medication for Osteoporosis with fracture? ☐ Yes ☐ No
14. Are you diabetic, and if so do you have or have you been treated for any of the following conditions: diabetic retinopathy, peripheral vascular disease, kidney disease, kidney failure, neuropathy, stroke, congestive heart failure, heart condition, or high blood pressure treated with more than two medications? ☐ Yes ☐ No

Do you take prescription medications? If yes, please list below all the prescription medications you are currently taking. Attach an additional sheet if necessary. ☐ Yes ☐ No

Prescription Medication Name	Date Originally Prescribed	Frequency and Dosage	**Diagnosis/Onset Date

**** PLEASE DO NOT LIST WATER PILL, WATER RETENTION, FLUID RETENTION OR BLOOD THINNER AS THESE ARE NOT MEDICAL CONDITIONS AND WILL REQUIRE A TELEPHONE INTERVIEW.**

Primary Physician Information

Name:

Address:

Telephone:

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No If yes, what is the effective date? _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

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 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 our application. PLEASE ANSWER ALL QUESTIONS. Please Mark Yes or No with an "X."

To the best of your knowledge:

1. Are you covered for medical assistance through the state Medi-Cal 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 Medi-Cal pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   (b) Do you receive any benefits from Medi-Cal OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No
2. (a) If you had coverage from a Medicare Advantage plan, or a Medicare HMO or PPO within the last 63 days fill in your start and end dates. START ___/___/___ END ___/___/___
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement plan to enroll in the Medicare plan? ☐ Yes ☐ No
3. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
   (b) If so, with which company: _____
   with which plan: _____
   and what paid-to-date do you have? _____
   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
4. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No
   (a) If yes, with what company, what kind of policy and reason for termination?
   _____
   (b) What are your dates of coverage under the other policy? START ___/___/___ END ___/___/___

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

(1) You do not need more than one Medicare Supplement Insurance 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 Insurance Policy.
(4) If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement Insurance 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 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 are available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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.

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-14 on Pages 1 and 2 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) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all 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, or a material misrepresentation was made to the individual; 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 or other involuntary termination of coverage 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 plan, 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; or

(f) Upon *first* becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or

(g) Lost eligibility for health benefits under Medi-Cal.

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

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Family Life Insurance Company, or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by Family Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Family Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Family Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Family Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 924408, Houston, Texas 77292-4408. I understand that such revocation will not have any effect on actions Family Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

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 unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (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.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application, or files a claim containing a false or deceptive statement, may be guilty of insurance fraud.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a ”Guide to Health Insurance for People with Medicare.”

Signed At: _____
(City /State)

Dated: _____ Applicant's Signature:_____
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____
_____
_____
_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____
_____
_____
_____

I certify that:
1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the policy applied for and a Guide To Health Insurance for People With Medicare to the Applicant.

Agent's Signature:	**Date:**
John Conner	AI01608
Agent's Printed Name:	**Agent No.:**

AUTHORIZATION

IN FAVOR OF: **Family Life Insurance Company**
Administrative office **P.O. Box 924408, Houston, Texas 77292-4408**

Name of Bank Customer:

Policy Numbers

Insured's Name:

Account Number : **Routing Number:**

☐ **Checking**
☐ **Savings**

To (Name of Bank):

Address of Bank:

You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Company indicated above, (hereinafter referred to as THE COMPANY), on my account by and payable to the order of The Company for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Company shall be the same as if it were a check drawn on 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 or other orders drawn by The Company. I further agree that if any such checks or other orders drawn by The Company 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 forfeiture of insurance.

Date | **Signature of Depositor**

Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.

AUTHORIZATION

To: **The Bank above**

In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree:

- To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith.
- In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance.
- To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection.

(Attach Voided Check)

AUTHORITY TO HONOR PREMIUM CHECKS

FAMILY LIFE
INSURANCE COMPANY

10700 Northwest Freeway
Houston, Texas 77092

Application For:

Medicare Supplement Insurance Coverage

(print clearly in blue or black ink)

SSN: ☐☐☐ ☐☐ ☐☐☐☐

Name: _____

UNDERWRITING AUTHORIZATION (Applicant)

I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Ingenix, or other organization, institution or person having any record of me available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me and any other non-medical information of me to give to Family Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Family Life Insurance Company may engage, any and all such information as permitted by law and the rules of Ingenix. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits. I agree that a photographic copy or a facsimile of this Authorization shall be as valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

This authorization includes any and all information you may have about me, including, but not limited to information regarding diagnosis, testing, treatment, and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, sickle cell testing and treatment, lab data, and EKGs. This information may also be disclosed to any medical records company engaged by Family Life Insurance Company, including, but not limited to Ingenix and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Family Life Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.

I understand that this authorization is required in order to enable Family Life Insurance Company to make eligibility, enrollment, benefit determinations, and underwriting and risk rating determinations relating to. If I refuse to sign or revoke this authorization, Family Life Insurance Company may refuse to consider my application for enrollment.

Signature: _____

Date: _____

PLEASE RETAIN A COPY FOR YOUR RECORDS