Enrollment Application

Follow these easy steps to apply for a Humana Achieve Medicare Supplement insurance policy.

1 Have Your Medicare Card Ready

Please print legibly and complete the entire form. You will need to fill in the information exactly as it appears on your Medicare card. Each person must complete a separate application.

2 Read and Complete Other Coverage Information

Be sure you read and understand the information before completing this section. **If you intend to replace your current Medicare Supplement policy or Medicare Advantage plan with this policy, be sure to complete the enclosed form titled Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage.**

3 Complete Guaranteed Acceptance

Please fill out this section if you are eligible for guaranteed acceptance. If a Notice of Replacement Form is required to be submitted with your application, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.

4 Read and Complete Medical Questions

5 Determine Your Premium

6 Determine Your Discount

7 Be Sure to Include Your Initial Premium Payment

Your first month's premium payment must be included. This is necessary even if you choose our Automatic Bank Withdrawal or Auto Credit Card Charge options for future premium payments.

8 Sign and Date the Enrollment Application

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Marking Instructions

- Please print clearly and press hard.
- **Use blue or black ink only.**
- Completely fill the ovals.

Correct Mark

Incorrect Marks

- Print legible numbers and capital block letters in the boxes.

Correct Numbers and Letters

1 2 3 A B C

- Print only one character per box.
- If you make a mistake, correct it by crossing out the box and writing the letter/number above or below the box as shown. Be sure to initial any and all corrections made.

- When filling out dates, such as effective dates or birth dates, be sure dates appear in the MMDDYYYY format. No dashes or spaces are necessary.

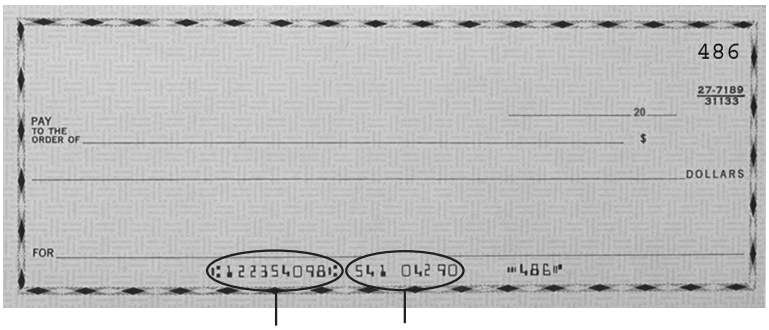
0 3 2 4 2 0 1 0

Required Fields Must Be Completed

Optional Fields

Sample Void Check

(If you are choosing the auto bank withdrawal.)



Routing Number **Account Number**

STAMP DATE MU001

CompBenefits Insurance Company
2432 Fortune Drive, Lexington, KY 40509

Form Number: TXAI85030-1

1

LAST NAME

FIRST NAME

MI

ADDRESS

APT OR STE#

ADDRESS (continued)

COUNTY

CITY

STATE

ZIP CODE

TELEPHONE

/ –

DATE OF BIRTH

M M D D Y Y Y Y

GENDER ○ M ○ F

MAILING ADDRESS (only if different from above street ADDRESS)

APT OR STE#

CITY

STATE

ZIP CODE

Select the policy you are applying for:

- ○ Plan A
- ○ Plan F*
- ○ Plan G
- ○ High Deductible Plan G
- ○ Plan N

* Only applicants eligible for Medicare prior to 1/1/2020 may purchase Plan F.

PROPOSED EFFECTIVE DATE

M M / 0 1 / 2 0 Y Y

Please complete the information below as it appears on your Medicare card.

MEDICARE NUMBER

IS ENTITLED TO — EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) M M / D D / Y Y Y Y

MEDICAL INSURANCE (PART B) M M / D D / Y Y Y Y

PERSON TO NOTIFY IN AN EMERGENCY (optional):

LAST NAME

FIRST NAME

MI

RELATIONSHIP TO APPLICANT

TELEPHONE

/ –

AGENT NUMBER (SAN)

➤ You Must Read and Sign

APPLICANT MEDICARE NUMBER

2 Other Coverage Information

- 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 more than one type of coverage in addition to your Medicare benefits.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB).

Yes or No answers are required to the following questions. If you have lost, or you are losing or replacing, 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. A copy of the notice from your prior insurer may be requested.

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, what is the effective date? M M / D D / Y Y Y Y
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.)
   a. If yes, 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? ◯ Yes ◯ No
3. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
   START M M / D D / Y Y Y Y END M M / D D / Y Y Y Y
   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? A Notice of Replacement Form is required to be completed. ◯ Yes ◯ No
   b. Was this your first time in this type of Medicare plan? ◯ Yes ◯ No
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ◯ Yes ◯ No
4. Do you have another Medicare Supplement policy in force? ◯ Yes ◯ No
   a. If so, with what company?
   What plan do you have?
   b. If so, do you intend to replace your current Medicare Supplement policy with this policy? A Notice of Replacement Form is required to be completed. ◯ Yes ◯ No
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) ◯ Yes ◯ No
   a. If so, with what company?
   What policy do you have?
   b. What are your dates of coverage under this policy? (If you are still covered under this policy, leave "END" blank.)
   START M M / D D / Y Y Y Y END M M / D D / Y Y Y Y
   c. Do you intend to replace your current healthcare coverage with this Medicare Supplement policy? ◯ Yes ◯ No

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

3 Guaranteed Acceptance

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ◯ Yes ◯ No
   If yes, please go directly to Section 5.
2. Based upon the definitions in the Guaranteed Acceptance Guide enclosed, are you eligible for guaranteed acceptance? ◯ Yes ◯ No
   If yes, please go directly to Section 5. Additionally, if you are submitting a Notice of Replacement, please provide the criteria qualifying you for guaranteed acceptance on the form. For example, if you qualify for guaranteed acceptance due to a Medicare Advantage plan exit, please check "Disenrollment from a Medicare Advantage plan" and indicate that your plan is exiting the market and no longer available.
3. Have you lost or are you losing Medicaid coverage qualifying you for guaranteed acceptance?
   ◯ Yes ◯ No
   If yes, please go directly to Section 5.

4 Medical Questions

IF YOU ARE APPLYING FOR COVERAGE DURING YOUR MEDICARE SUPPLEMENT OPEN ENROLLMENT PERIOD OR QUALIFY FOR GUARANTEED ACCEPTANCE, YOU ARE NOT REQUIRED TO ANSWER THE FOLLOWING QUESTIONS. A MEDICAL RECORDS RELEASE AUTHORIZATION FORM IS REQUIRED.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

HEIGHT Y **FT** Y Y **IN** **WEIGHT** Y Y Y **LBS**

1. In the last year, have you been hospitalized, confined to a nursing facility, or are you bedridden or confined to a wheelchair? ◯ Yes ◯ No
2. In the past 90 days have you received Home Health care? ◯ Yes ◯ No
3. Have you used supplementary oxygen in the last year? ◯ Yes ◯ No
4. Do you now have or within the last two years have you taken medication or been advised to take medication for or received medical treatment or been advised that you need treatment or surgery for:
   a. Heart, Coronary, or Carotid Artery Disease, high blood pressure (hypertension) or high cholesterol, Peripheral Vascular Disease, Congestive Heart Failure or any other type of Heart Failure, Stroke, Transient Ischemic Attacks (TIA), or Heart Rhythm disorders? ◯ Yes ◯ No
   b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other Chronic Pulmonary disorders?
   ◯ Yes ◯ No
   c. Parkinson's Disease, Multiple or Lateral Sclerosis, Huntington's Disease, Muscular Dystrophy, Systemic Lupus, Hepatitis (excluding A or E), Lou Gehrig's Disease? ◯ Yes ◯ No
   d. Inflammatory Bowel Disease, Crohn's Disease, Ulcerative Colitis, or Barrett's Esophagus? ◯ Yes ◯ No
   e. Alzheimer's Disease, senile dementia, brain seizures, epilepsy, senility disorder, schizophrenia, major depressive disorders, other mental or nervous disorders, liver disease or disorder, cirrhosis, alcoholism or drug abuse?
   ◯ Yes ◯ No
   f. Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC), Human Immunodeficiency Virus (HIV) infection or blood disorder? ◯ Yes ◯ No
   g. Kidney disease requiring dialysis or Kidney failure? ◯ Yes ◯ No
   h. Diabetes? ◯ Yes ◯ No
   i. Internal cancer, leukemia or melanoma? ◯ Yes ◯ No
   j. Amputation caused by disease or trauma or neuralgic or poor circulation that has caused an ulcer on the skin? Do you have any paralytic conditions? ◯ Yes ◯ No
   k. Rheumatoid arthritis, Paget's Disease, Osteoporosis, degenerative bone or joint disorder, degenerative disk disease, crippling arthritis, vertebral or hip fractures/dislocations, spinal cord disorders/injuries, or chronic pain?
   ◯ Yes ◯ No

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

l. Organ, bone marrow or stem cell transplant or awaiting transplant (excluding corneas)? ◯ Yes ◯ No

5. Please list any prescription drugs (full medication name) you are currently taking or have taken within the past 12 months:

_____

_____

_____

5 Premium Determination

If applying during your Medicare Supplement Open Enrollment Period or if you qualify for guaranteed acceptance, please skip the first question as it does not apply to your premium determination. If you did not answer "Yes" to either question in Section 3, please answer both questions. All applicants must answer the second question in this section.

1. Did you have Medicare coverage prior to age 65? ◯ Yes ◯ No
2. Have you used tobacco products within the last 12 months? ◯ Yes ◯ No

If your application is accepted, and you answered **No** to both questions, you qualify for the Preferred rates. You also qualify for the Preferred rates if you are age 65 or older and a non-tobacco user applying during open enrollment or you qualify for guaranteed issue. To determine your premium, refer to your Outline of Coverage.

6 Discount Determination

If you qualify for the Enhanced Household Discount disclosed in your Outline of Coverage, please provide the name of the individual living at your current address.

LAST NAME **FIRST NAME** **MI**

7 Payment Options

PREMIUM QUOTE

. **Premium quoted based on all applicable discounts.**

INITIAL PAYMENT

. **Amount you are submitting with your application. You must submit at least your first month's premium with all applicable discounts.**

CHECK NUMBER **Please indicate ACH in the Check Number fields if this is the preferred method for initial premium payment.**

MONEY ORDER

DEPOSITORY BANK NAME

ROUTING NUMBER **ACCOUNT NUMBER** ◯ **Checking** ◯ **Savings**

CREDIT CARD NAME ◯ **MasterCard** ◯ **Visa** ◯ **Discover**

CREDIT CARD NUMBER **EXPIRATION DATE** M M Y Y Y Y

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

Future Payment options: ◯ **Same as above** ◯ **Automatic Withdrawal** ◯ **Coupon Book** ◯ **Auto Credit Card Charge**

DEPOSITORY BANK NAME

ROUTING NUMBER **ACCOUNT NUMBER** ◯ **Checking** ◯ **Savings**

If you choose the auto credit card charge option, complete the following: ◯ **MasterCard** ◯ **Visa** ◯ **Discover**

CREDIT CARD NUMBER **EXPIRATION DATE** M M Y Y Y Y

I hereby authorize Humana to initiate debit/credit entries to my checking/savings account or my credit card account, as indicated above, in amounts appropriate to my coverage; and authorize the bank named above to debit/credit the same to such account. I authorize Humana to change the amount of the debit/credit, provided that I am given advance written notice. This authorization is to remain effective until I give Humana and the bank reasonable notice of termination.

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Humana has the right to reject my application and any premiums paid will be refunded. I also understand that the policy will not pay benefits for medical expenses incurred during the first three months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date. Coverage is not limited if you enroll during an open enrollment or guaranteed issue period or satisfy the creditable coverage requirements.

Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a false or deceptive statement may be subject to prosecution for fraud.

The undersigned applicant certifies that the applicant has read, or had read to him or her, the completed application and that the applicant realizes that any false statement or material misrepresentation in the application may result in loss of coverage under the policy. The applicant further acknowledges receipt of the currently available Outline of Coverage , Medicare Supplement Guaranteed Acceptance Guide, and the “Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare” publication.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement 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 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 the suspension.

➤ **You Must Read and Sign**

APPLICANT MEDICARE NUMBER

8 Signature & Date

APPLICANT'S SIGNATURE:

SIGNATURE DATE: / /

AGENT'S SIGNATURE:

SIGNATURE DATE: / /

TO BE COMPLETED BY SALES AGENT - PLEASE LIST All health insurance policies sold to the applicant which are still in force and all health insurance policies sold to the applicant within the past five years which are no longer in force.
A response is required. NONE or Not Applicable ◯

COMPANY TYPE

COMPANY TYPE

If you are the authorized legal representative, you **must** sign above on behalf of Applicant and provide the following information:

LAST NAME FIRST NAME MI

STREET ADDRESS

CITY ST ZIP

TELEPHONE / – RELATIONSHIP TO APPLICANT

AGENT USE ONLY

WRITING AGENT NAME

WRITING AGENT ID (SAN) COMMISSION LEVEL MGA CODE MKTS 5 4 AFFINITY CODE

AGENCY (optional) AGENCY ID (SAN)

➤ **You Must Read and Sign**

Insured by CompBenefits Insurance Company

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Important

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, ancestry, ethnicity, sex, sexual orientation, gender, gender identity, disability, age, marital status, religion, or language in their programs and activities, including in admission or access to, or treatment or employment in, their programs and activities.

- The following department has been designated to handle inquiries regarding Humana's non-discrimination policies: Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618, **877-320-1235 (TTY: 711).**

Auxiliary aids and services, free of charge, are available to you. 877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

This information is available for free in other languages. Please call our customer service number at 877-320-1235 (TTY: 711). Hours of operation: 8 a.m. – 8 p.m. Eastern time.

Español (Spanish): Llame al número indicado para recibir servicios gratuitos de asistencia lingüística. **877-320-1235 (TTY: 711).** Horas de operación: 8 a.m. a 8 p.m. hora del este.

繁體中文 (Chinese): 本資訊也有其他語言版本可供免費索取。請致電客戶服務部：**877-320-1235（聽障專線：711）**。辦公時間：東部時間上午 8 時至晚上 8 時。

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

CompBenefits Insurance Company • P.O. Box 14309, Lexington, KY 40512-4309

Save this notice! It may be important to you in the future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy/certificate to be issued by CompBenefits Insurance Company. Your new policy/certificate will provide 30 days within which you may decide - without cost - whether you desire to keep the policy/certificate. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare Supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

Statement to the Applicant by Issuer, Agent (Broker or other Representative)

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/certificate is being purchased for the following reasons:

- ☐ additional benefits
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan (please explain reason for disenrollment)
- ☐ no change in benefits, but lower premiums
- ☐ other (please specify)

_____

_____

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy/certificate and replace it with new coverage, 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/certificate 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/certificate until you have received your new policy/certificate and are sure that you want to keep it.

Applicant's signature	Signature of agent/broker/representative	
Print name	Print name and address of agent or broker below	
Social Security number		Date

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Medical Records Release Authorization

Purpose of the Authorization

By signing this form, you will authorize the disclosure and use of the protected health information described below for pre-enrollment underwriting or to determine your eligibility for enrollment or benefits under an insurance plan.

Information we will use and/or disclose

I authorize any physician, medical or health care practitioner, hospital, clinic, veterans administration facility, other medical or medically related facility, third party administrator, Pharmacy Benefit Manager, insurance, HMO or reinsuring company, employer or the Consumer Reporting Agency having information regarding myself including information concerning advice, diagnosis, treatment and care of the physical, psychiatric, mental or emotional conditions, drug, substance or alcohol abuse, illness and copies of all hospital or medical records, non-public personal health information and any other non-medical information to share any and all such information with CompBenefits Insurance Company, its reinsurer or its legal representatives, and its affiliates.

- The information obtained by use of this authorization may be used by CompBenefits Insurance Company to determine eligibility for coverage.
- Any information obtained will not be released by CompBenefits Insurance Company to any person or organization except to reinsuring companies, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim or as may be otherwise lawfully required, or as we may further authorize. If a Consumer Reporting Agency is used, I may request to be interviewed in connection with the preparation of the report and I may request a copy of the report.
- Once personal and health (including medical and pharmacy) information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal and state privacy requirements.

Expiration and revocation

- A copy of this authorization is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original.
- This authorization shall be valid for 2 years from the date shown below. I have the right to revoke this authorization at any time.
  To revoke this authorization:
  - I must do so in writing and send my written revocation to Humana's Privacy Office (Humana Privacy Office, P.O. Box 1438 Louisville, KY 40202).
  - The revocation will not apply to information that has already been released in response to this authorization.
  - The revocation may adversely affect my application, a claim or a pending insurance action.
  - The revocation will become effective after it is received by Humana's Privacy Office.

If you were required to answer medical questions on your Medicare Supplement Enrollment Application, you must complete this authorization to be eligible for enrollment.

LAST NAME **FIRST NAME** **MI**

MEDICARE NUMBER **SOCIAL SECURITY NUMBER** – –

DATE
M M / D D / Y Y Y Y

Applicant Signature _____ Date _____

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Medicare Supplement Guaranteed Acceptance Guide

Definitions of Eligible Person for Guaranteed Acceptance and Creditable Coverage

The following are definitions of the categories of the individuals who are eligible for Guaranteed Acceptance:

1. Enrolled under an employee welfare benefit plan that either:
   (a) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or
   (b) 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
2. Enrolled in a Medicare Advantage plan or 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provided under Section 1894 of the Social Security Act and the organization's certification or plan is terminated or the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides or the individual is no longer eligible to elect the plan because of change in circumstances, but not including termination of enrollment where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior, or the plan is terminated for all individuals within a residence area; or the organization substantially violated a material policy provision; or a material misrepresentation was made to the individual; or
3. 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
4. Enrolled in a Medicare Supplement policy and policy and coverage discontinues due to insolvency, bankruptcy and other involuntary termination of coverage, substantial violation of a material policy provision, or material misrepresentation; or
5. Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a Medicare Cost, with a similar organization operating under demonstration project authority, a PACE Program, or a Medicare Select Plan, and then the insured person terminates coverage within 12 months of enrollment; or
6. Upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolled in a Medicare Advantage or in a PACE Program and disenrolls within 12 months; or
7. Enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, is enrolled under a Medicare supplement policy that covers outpatient prescription drugs and terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application; or
8. Loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

If any of the definitions apply to you, please complete an application for Medicare Supplement insurance and submit evidence of the date of termination or disenrollment. Application must be made for coverage no later than 63 days of termination or disenrollment.

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Medicare Supplement Guaranteed Acceptance Guide *(Continued)*

The following is a definition of Creditable Coverage:

Creditable Coverages means

(a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.)

(b) group health plan;

(c) individual health insurance policy or evidence of coverage;

(d) Part A or Part B of Title XVIII of the Social Security Act (Medicare);

(e) Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928;

(f) Chapter 55 of Title 10 United States Code (TRICARE);

(g) a medical care program of the Indian Health Service or of a tribal organization;

(h) a state or political subdivision health benefits risk pool;

(i) a health plan offered under Chapter 89 of Title 5 United States Code (Federal Employees Health Benefits Program);

(j) a public health plan as defined in federal regulation;

(k) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504 (e));

(l) Short-term limited duration insurance.

I acknowledge receipt of this Supplementary Application.

_____ _____

Signature of Applicant Date

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