

# Simple Instructions

- 1. Print and complete the application
- 2. Include a check for one month's premium
- 3. Mail your application to:

For free postage, cut and paste this label onto your envelope.

NO POSTAGE  
NECESSARY  
IF MAILED  
IN THE  
UNITED STATES

**BUSINESS REPLY MAIL**  
FIRST-CLASS MAIL      PERMIT NO. 679      NORTHRIDGE, CA  
POSTAGE WILL BE PAID BY ADDRESSEE

HEALTH AND LIFE INSURANCE SERVICES  
APPLICATION PROCESSING CENTER  
9510 SYLVIA AVENUE  
NORTHRIDGE, CA 91324-9904



**Questions? Call: 1-800-243-8100**



**Aetna Individual Medicare Supplement Plan Application**  
**Aetna Life Insurance Company**  
For California Residents Only

1 APPLICANT INFORMATION (Proposed Insured) – Please Print			
Last Name		First Name	
Social Security Number		<input type="checkbox"/> Male	MI
		<input type="checkbox"/> Female	Birth Date (MM/DD/YYYY)
Street Address (Number, Street, Apt.)			
City	State	ZIP Code	County
Billing Address (if different from above)			
Telephone Number ( )		Primary Language Spoken (optional)	
Email Address (optional)			

2 MEDICARE INFORMATION – Please fill out this information exactly as it appears on your Medicare card.	
<b>MEDICARE ● HEALTH INSURANCE</b>	
<b>CENTERS FOR MEDICARE &amp; MEDICAID SERVICES</b>	
NAME OF BENEFICIARY	
MEDICARE CLAIM NUMBER	
IS ENTITLED <span style="float: right;">EFFECTIVE DATE</span>	
<b>HOSPITAL (PART A)</b>	
<b>MEDICAL (PART B)</b>	

3 SECONDARY ADDRESSEE INFORMATION – A copy of any notification of possible lapse will be sent to this person.	
Name: _____	
Address: _____	

**4 MEDICAL AND GENERAL** (A telephone interview with the applicant may be conducted to verify application)  
 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.**

Please Mark **Yes** or **No** with an "X"

**To the best of your knowledge,**

<p>(1) Did you turn age 65 in the last 6-months? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(a) Did you enroll in Medicare Part B in the last 6-months? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) <b>IF YES</b>, what is the effective date? _____</p> <p>(c) If you are under age 65, have you been diagnosed with or treated for End-Stage Renal Disease (ESRD)? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(2) Are you covered for medical assistance through the the state Medi-Cal program? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>(NOTE TO APPLICANT:</b> If you have a "Share of Cost" under the Medi-Cal program, please answer <b>NO</b> to this question.</p> <p><b>IF YES,</b></p> <p>(a) Will Medi-Cal pay your premiums for this Medicare supplement policy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(b) Do you receive any benefits from Medi-Cal OTHER THAN payments towards your Medicare Part B premium? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(3) If you had coverage from any Medicare plan other than the Medicare plan within the last 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 ____ / ____ / ____ END ____ / ____ / ____</p>	<p>(a) 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</p> <p>(b) Was this your first time in this type of Medicare plan? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(4) Do you have another Medicare supplement policy in force? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES,</b></p> <p>(a) With what company and what plan do you have?        _____</p> <p>(b) Do you intend to replace your current Medicare supplement policy with this policy? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(5) Have you had coverage under any other health insurance plan within the past 63 days? (for example, an employer, union or individual plan) ..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>IF YES,</b></p> <p>(a) With what company and what kind of policy?        _____</p> <p>(b) What are your dates of coverage under the policy? (if you are still covered under the other policy, leave "END" blank).        START ____ / ____ / ____ END ____ / ____ / ____</p>
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PLEASE MAKE A COPY FOR YOUR RECORDS

Name _____	Social Security Number _____
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**5 PLAN SELECTION** (Note: Please make checks payable to **Aetna Life Insurance Company**.)

Premium Period: <input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	Insurance Plan Applied For: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan F	Initial Premium (submit one month only) _____ (This amount, which can be found in the enclosed materials, must accompany the application.) <b>Requested effective date:</b> _____
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**6 GUARANTEED ISSUE OR OPEN ENROLLMENT**

Please refer to the Guaranteed Issue Guidelines furnished with the Outline of Coverage. If you are applying during open enrollment or if you are eligible for guaranteed issue, please indicate which open enrollment or guaranteed issue provision applies to you with respect to this Medicare supplement application: \_\_\_\_\_

**Please attach a copy of your termination notice, HIPAA certificate or other correspondence to validate your eligibility for open enrollment or guaranteed issue.**

**7 STATEMENT OF HEALTH QUESTIONS** (Please answer the following questions to the best of your knowledge.)

**Please note: If you are applying during open enrollment or you are eligible for guaranteed issue, you are not required to answer the following health questions.**

1.	Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, receiving home health care in the past 90 days; or has any such care been medically advised by a licensed medical practitioner?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
2.	<b>In the past two (2) years</b> , have you been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
3.	<b>In the past two (2) years</b> , have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for Alzheimer's Disease, Senile Dementia, Organic Brain Disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease, Muscular Dystrophy or paralysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
4.	<b>In the past two (2) years</b> , have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for Diabetes requiring the use of Insulin, kidney failure, kidney dialysis, received an organ transplant or awaiting an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
5.	<b>In the past two (2) years</b> , have you consulted a physician, licensed medical provider, been diagnosed, treated or advised to have treatment for:																	
	<b>a.</b> Congestive Heart Failure, Heart Attack, Angina (chest pain), Coronary Artery Disease, Cardiomyopathy, Stroke (CVA), Transient Ischemic Attack (TIA), Heart Rhythm Disorders requiring pacemaker or defibrillator?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	<b>b.</b> Heart or circulatory surgery of any type including Angioplasty, Bypass, Stent Placement or a Valve Replacement?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	<b>c.</b> Cancer (except skin cancer), Melanoma, Hodgkin's Disease, Leukemia or Multiple Myeloma?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	<b>d.</b> Mental or Nervous Disorder requiring Psychiatric care, Alcohol or Drug Abuse (prescription or non-prescription), Cirrhosis of the Liver or Hepatitis C?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	<b>e.</b> Disabling/Crippling Arthritis, Osteoporosis with compression fractures, Degenerative Bone Disease, Systemic Lupus, or any other Connective Tissue Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	<b>f.</b> Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other Lung Disease, or require the use of oxygen therapy to assist in breathing?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
6.	Have you been hospitalized two or more times within the past 24 months (2 years)?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
7.	Have you been advised by a licensed medical provider to have surgery, medical tests or treatment that has not been performed or have had medical test(s) for which you have not received the results?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
8.	Have you taken any prescription medications within the past 12 months (1 year)? If <b>YES</b> , provide details below (attach a separate sheet if necessary):	<input type="checkbox"/> Yes <input type="checkbox"/> No																
	<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:35%;">Medication</th> <th style="width:15%;">Dosage</th> <th style="width:35%;">Medication</th> <th style="width:15%;">Dosage</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>	Medication	Dosage	Medication	Dosage													
Medication	Dosage	Medication	Dosage															
9.	Have you smoked or used any tobacco product within the past two (2) years?	<input type="checkbox"/> Yes <input type="checkbox"/> No																
10.	<b>List current height</b> _____ <b>weight</b> _____																	

**PLEASE MAKE A COPY FOR YOUR RECORDS**

Name	Social Security Number
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**8 RELEASE AUTHORIZATION – PLEASE READ CAREFULLY BEFORE SIGNING**  
 Please sign and date where indicated on this page. PLEASE MAKE A COPY FOR YOUR RECORDS

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this Application and applying for this coverage, I agree to or with the following:

1. Aetna may decline this Application. No coverage comes into effect until Aetna approves this Application.
2. Coverage and benefits, once they come into effect, are contingent on a timely and accurate payment of premiums and any other contribution provided in the plan documents. If premium payments are not paid on time and accurately, your coverage will be terminated. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in Aetna's Individual Medicare Supplement Plan.
3. I authorize Aetna to request my medical records, any prescribed medication history and any other medical or pharmaceutical information to process my Application and to make a decision on the approval or disapproval of my Application. I authorize any physician, other healthcare professionals, hospital, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment or any other service to me to disclose the information required by Aetna and described above to Aetna and/or its designated agents. I understand that I may revoke this authorization at any time while Aetna is determining eligibility for the coverage requested. To do so, I must notify Aetna in writing prior to the issuance of the policy. Revocation of this authorization will result in the closure of my Application.
4. I understand that Aetna will rely on such information to: 1) underwrite this Application for coverage, make eligibility, risk rating, policy issuance and enrollment determination; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations. I authorize Aetna to use such information and to disclose such information to affiliates, Providers, payers, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that Aetna will comply with the HIPAA Privacy Rules and that disclosure of such information will be done in accordance with applicable law.
5. I understand that I am entitled to receive a copy of this Application upon request, and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of Aetna.
7. Information on insurance agent/broker compensation is available from your agent or at Aetna.com.
8. I have an obligation of communicating to Aetna in writing any medical conditions which occur to Applicant listed in this Application after the Application date and before the effective date of the coverage, if approved.
9. **Attention California Residents:** For your protection, California law requires notice of the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.  
**NOTICE: CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.**

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my application will be declined.

I acknowledge receipt of a copy of "A Guide to Health Insurance for People with Medicare" and an Outline of Coverage, and that I have made a copy of this Application.

Applicant's Signature:  \_\_\_\_\_ Application Date: \_\_\_\_\_

Power of Attorney or Legal Guardian Signature\*: \_\_\_\_\_

\* If Applicant is unable to sign, a court-appointed legal guardian or a designee authorized by state law must sign above.

Attach a copy of the document that designates this person as the Applicant's representative.

**9 PRODUCER CERTIFICATION – This Section To Be Completed By Producer/Aetna Sales Representative Only**

The undersigned Agent certifies that the Applicant has read, or had read to him/her, 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.

List all health insurance policies (including Medicare Supplement policies) you have sold to the applicant which are still in force. (attach separate sheet, if necessary)

Company: \_\_\_\_\_ Type: \_\_\_\_\_

List all health insurance policies sold to the applicant within the past 5 years which are no longer in force.

Company: \_\_\_\_\_ Type: \_\_\_\_\_

I certify: (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 I reviewed the current health insurance coverage of the Applicant and find additional coverage of the type and amount applied for the Applicant's needs is:

Appropriate  Inappropriate

Signature of Producer: \_\_\_\_\_ Date signed: \_\_\_\_\_

Name of Insurance Producer or Agency to be assigned as Broker of Record: Health And Life Insurance Services

TIN of Producer or Agency to be assigned as Broker of Record: 954657410 SS# if Payee is an Individual: \_\_\_\_\_

Signature of General Agent or FMO (required if applicable) \_\_\_\_\_ Date signed: \_\_\_\_\_

Name of General Agent or FMO (required if applicable): \_\_\_\_\_

TIN of General Agent or FMO: \_\_\_\_\_ SS# if Payee is an Individual: \_\_\_\_\_

Address and Telephone Number: 1-800-243-8100 Office - 1-800-501-9222 Fax

PLEASE NOTE: When commission is to be paid only to a Producer, include only Producer-specific information. When commission is to be paid to a Broker, Agency, GA or FMO, the TIN and signature are required.

Send Policy to:  Agent  Insured

**PLEASE MAKE A COPY FOR YOUR RECORDS**

## Save yourself the time and trouble of bill paying ...

Sign up for the Aetna Electronic Funds Transfer Program and your monthly Aetna Individual Medicare Supplement Plan premium will be automatically withdrawn from your checking account or credit card account on the date it's due.

### Who is eligible?

If you are covered by an Aetna Individual Medicare Supplement Plan insurance policy and have a credit card or checking account, you may apply.

### When does it begin?

For bank drafts, billing starts on the seventh day of your next billing month (or the first business day thereafter if the seventh falls on a holiday or weekend) and on the next Friday for credit card payments. Please continue to send payments by mail until then. Ongoing premium payments will be withdrawn according to this schedule.

### Why should I sign up?

The Aetna Electronic Funds Transfer Program helps you save on your costs for checks, envelopes and postage. Plus, you never have to worry about your plan premiums payment being late.

### APPLY TODAY

Simply complete the attached application and return it to Aetna in the postage-paid envelope. You'll know your request has been processed when your first premium payment clears the account you selected. This generally happens within 30-60 days of sending in your application.

If you have questions about this offer, call: 1-800-557-5078. Or, for the hearing impaired, call: 1-888-200-6124. Please notify us of any account changes, including new expiration dates, during the call.



### IMPORTANT – Please read and sign.


**Terms of Agreement:** I have an account at the financial institution named and, for all debit and charge entries, have funds sufficient to pay such entries. Electronic debit, charge or credit entries shall be initiated by Aetna to pay plan premiums and other charges for the listed health care policies or other policies as authorized, and the entries shall constitute my receipt for the transaction(s). No payment to Aetna shall be deemed to have been made unless and until Aetna receives final credit for the payment.

I also understand that if corrections to the entry are necessary, they may involve an adjustment to my account. I understand my direct electronic payment of the plan premium will be debited or charged on or after the premium due date, the first of every month.

**NOTE:** Aetna reserves the right to refuse or terminate electronic payment services at any time. This agreement is to remain in effect until Aetna or the policyholder terminates it. Aetna may require 48 hours to process the policyholder's notice of termination.

Aetna Individual Medicare Supplement Plan policyholders must continue to pay their Part B premium and Part A if applicable.

Joint accounts require the signature of ALL persons having authority over the account. Please be sure all joint account holders sign below regardless of whether he/she is applying.

Signature  \_\_\_\_\_

Signature X \_\_\_\_\_

### BILLING AUTHORIZATION APPLICATION

Policyholder's Aetna Individual Medicare Supplement Plan ID No. \_\_\_\_\_

#### Here's How to Apply:

1. Fill out the information below, where applicable
2. Choose a billing option.
3. If the deductions will be made from a checking account, please include a blank check marked "VOID" showing the preprinted account number.
4. Please be sure to sign this application.

### YES! I'm applying for the Aetna Electronic Funds Transfer Program.

#### BILLING OPTIONS:

- Checking Account Option

Name(s) on Checking Account \_\_\_\_\_

Checking Account No. \_\_\_\_\_

- Credit Card Option

Name(s) on Card \_\_\_\_\_

Cardholder Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

- VISA™

- MasterCard™

Account No. \_\_\_\_\_

Expiration Date \_\_\_\_\_

"Aetna" is the brand name used for products and services provided by one or more of the Aetna group or subsidiary companies. Health insurance plans are underwritten by Aetna Life Insurance Company. The Aetna Individual Medicare Supplement Plan is administered by CHCS Services, Inc.



# NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

**Aetna Life Insurance Company  
PO Box 13547, Pensacola, FL 32591-3547**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

If you intend to cancel or terminate existing Medicare supplement or Medicare Advantage insurance and replace it with coverage issued by Aetna Life Insurance Company, please review the new coverage carefully and replace the existing coverage ONLY if the new coverage materially improves your position. DO NOT CANCEL YOUR PRESENT COVERAGE UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE THAT YOU WANT TO KEEP IT.

If you decide to purchase the new coverage, you will have 30 days after you receive the policy to return it to the insurer, for any reason, and receive a refund of your money.

If you want to discuss buying Medicare supplement or Medicare Advantage coverage 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.

## STATEMENT TO 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 is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
- Other. (Please specify) \_\_\_\_\_

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitation, please skip to statement 2 below. Health conditions which you may presently have (preexisting 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 preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting 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 and replace it with the new coverage, be certain to truthfully and completely answer all questions in the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for Aetna Life Insurance 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	Date
Typed Name and Address of Issuer or Agent	
Applicant's Signature 	Date

**PLEASE MAKE A COPY FOR YOUR RECORDS**

**INSTRUCTIONS:**

To be considered complete, all sections on this form must be filled out, unless marked optional. Please sign and date the form and make a copy for your records. **Incomplete forms could delay processing your enrollment.** For information call **1-800-557-5078**; TTY/TDD (Hearing Impaired) **1-888-200-6124**.

**PLEASE READ THE FOLLOWING CONSUMER PROTECTION 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 whether you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this extension 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 reinstated 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 reinstated 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 reinstated 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 reinstated 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 this state to provide advice concerning your purchase of Medicare Supplement insurance and 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.