

# Simple Instructions

1. Print and complete the application
2. Include a voided check
3. Fax or mail your application to:

Fax: 1-800-501-9222

or

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

<b>BUSINESS REPLY MAIL</b>			<p>NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES</p> 
FIRST-CLASS MAIL	PERMIT NO. 679		
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**

Application for California Residents Only  
**Blue Shield of California**  
**Medicare Supplement plans**



Fax to: 1-800-501-9222

FOR OFFICE USE ONLY		
Accept. code _____	Plan type _____	Market code _____

**Here's how to apply**

- 1 Provide ALL requested information and print clearly in blue or black ink.
- 2 Sign and date in all places indicated.
- 3 Within 30 days of your signature date, mail the application in the enclosed postage-paid envelope. Keep the yellow copy for your records.
- 4 Please submit your first payment along with your application. Blue Shield will refund your payment if your application is not approved.

**Personal information**

First name	Middle initial	Last name
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Home address

City	State <b>CA</b>	ZIP
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Home telephone	E-mail address
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Mailing address (if different from above)

City	State	ZIP
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Billing address (if different from above)

City	State	ZIP
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Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth ____ - ____ - ____ Month Day Year
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Medicare number	Social Security number
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I'm entitled to:  Hospital (Part A) effective date \_\_\_\_\_  
 Medical (Part B) effective date \_\_\_\_\_

Please check the plan type you are applying for:  A  C  D  F  K

Requested effective date: The  1<sup>st</sup> day or  15<sup>th</sup> day of \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Month Year

Language preference  English  Spanish  Chinese  Vietnamese  Other \_\_\_\_\_

**Medicare Prescription Drug Plan information**

Have you purchased a Medicare prescription drug plan?  Yes  No

**If Yes,**  
a. With what company? \_\_\_\_\_ b. What is the effective date? \_\_\_\_\_

## Guaranteed acceptance

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If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

**I believe I qualify for guaranteed acceptance based on situation number** \_\_\_\_\_ .

If applying for guaranteed acceptance under situation No. 2 on the enclosed Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form and submit with your completed enrollment application.

## Two-party contracts

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**You and your spouse or domestic partner may qualify for a TWO-PARTY CONTRACT.** Both individuals must be age 65 or older, enrolled in both Medicare Parts A and B, and apply for the same plan type. Each individual must complete their own applications. Either person who does not qualify for guaranteed acceptance (see above) will be subject to underwriting.

1. If you and your spouse/domestic partner are applying for a two-party contract, please check this box:
2. Is your spouse/domestic partner currently enrolled in a Blue Shield Medicare Supplement plan?  Yes  No
  - a. If Yes which plan type? \_\_\_\_\_

Please provide

1. Your spouse/domestic partner's name: \_\_\_\_\_
2. Spouse/domestic partner's Social Security number: \_\_\_\_\_
3. Spouse/domestic partner's authorization to change their contract to a two-party contract by signing below:

Spouse/domestic partner signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print name \_\_\_\_\_

- b. If No, and you are both currently applying for coverage, you and your spouse/domestic partner must each complete your own application. On each application, please provide your spouse/domestic partner's name and social security number.

## Payment information

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Please include your first payment along with your application. To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement plans Summary of Benefits and Provisions. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

- Check enclosed with this application, or  
 Check enclosed with spouse/domestic partner's application\*

\* If you are applying for a two party contract for you and your spouse/domestic partner, please enclose only one check for the applicable two-party rate, which can be found in the Summary of Benefits.

Select your payment choice:

- Easy\$Pay<sup>SM</sup> (automatic monthly debit from your checking or savings account – you must complete the enclosed Automatic Payment form)
- Credit card payment (automatic monthly or quarterly charge – you must complete the enclosed Automatic Payment form)
- I already participate in Blue Shield's Automatic Payment, and would like to continue my authorization for automatic charge/debit of dues for the rate applicable to the plan identified above, if my application is approved.
- Quarterly billing     Monthly billing

## Current insurance coverage information

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 contract, or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance. Please include a copy of the notice from your prior insurer with your application.

**Please answer all questions.** (Please mark Yes or No below with an X.) To the best of your knowledge,

- 1  Yes  No a. Did you turn 65 years of age in the last 6 months?  
 Yes  No b. Did you enroll in Medicare Part B in the last 6 months?  
c. If yes, what is the effective date? \_\_\_\_\_

- 2  Yes  No Are you covered for medical assistance through California's Medi-Cal program?  
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

**If Yes,**

- Yes  No a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?  
 Yes  No b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

- 3  Yes  No 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 the "END" blank.

Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Carrier name: \_\_\_\_\_ Carrier phone No.: \_\_\_\_\_

Member No.: \_\_\_\_\_

**If Yes,**

- Yes  No a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?  
 Yes  No b. Was this your first time in this type of Medicare plan?  
 Yes  No c. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?

- 4  Yes  No Do you have another Medicare Supplement plan policy or certificate or contract in force?  
a. If so, with what company? \_\_\_\_\_ What plan do you have? \_\_\_\_\_  
 Yes  No b. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract?

- 5  Yes  No Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? If so, what companies and what kind of policy?  
Carrier name: \_\_\_\_\_ Carrier phone No.: \_\_\_\_\_  
Current ID No.: \_\_\_\_\_  
What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "END" blank.) Start \_\_\_\_ / \_\_\_\_ / \_\_\_\_ End \_\_\_\_ / \_\_\_\_ / \_\_\_\_

- 6  Yes  No Are you under age 65?  
**If Yes,** a. Do you have end-stage renal disease?  Yes  No

**You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.**

**A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-HMO-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's Internet Web site (www.dmhc.ca.gov).**

## Terms, conditions, and authorizations

**Information regarding Medicare Supplement plan coverage:** Before you apply, it's important that you read the following information, then sign and date at the end of this application.

- 1 You do not need more than one Medicare Supplement plan policy or contract.
- 2 If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
- 3 You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.
- 4 If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 5 If you are eligible for, and have enrolled in, a Medicare Supplement plan contract 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 plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 6 Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.

## Conditions of membership

- 1 This application and the Statement of Health, together with the *Evidence of Coverage and Health Services Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
- 2 I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
- 3 Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.
- 4 I acknowledge receipt of the Summary of Benefits and a copy of this application. I have read the Summary of Benefits and the terms, and conditions of coverage set forth above. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided.

**Applicant's signature**

**Date**



**Producer information – Must be completed by producer**

Producer number <b>954657410E</b>	Telephone number <b>1-800-243-8100</b>	<input type="checkbox"/> Update	Fax number <b>1-800-501-9222</b>	<input type="checkbox"/> Update
Producer name <b>Health And Life Insurance Services</b>				
E-mail address				<input type="checkbox"/> Update
Producer address				<input type="checkbox"/> Update
City		State	ZIP	

**Section 1 – Please list any other health insurance policies or plan contracts they have sold to the applicant as follows:**

List policies and plan contracts sold that are still in force: \_\_\_\_\_

List policies and plan contracts sold in the past five years that are no longer in force: \_\_\_\_\_

**Section 2 – If the applicant did not complete the Statement of Health section (is guaranteed acceptance), you do not need to complete this section.**

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

**Review and select one of the following:**

- I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.
- I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to \$10,000.

Super Producer name	Super Producer number	
<b>Today's date (required)</b>	<b>Producer's signature (required)</b>	<b>Print name</b>

**Notice:** Please ensure each part of the application is complete. In the event of missing or incomplete information Blue Shield may contact your applicant directly to obtain complete information.

Do you want the service agreement/policy sent directly to the subscriber?  Yes  No

## Statement of health

**Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided.**

**If you qualify for guaranteed acceptance, do not complete this section.** (See the Guaranteed Acceptance section for qualifying information). Otherwise, please answer Yes or No to each of the following questions:

- 1** Have you, within the past three years, received treatment or been hospitalized for any of the conditions listed below?  
If Yes, please explain the condition and indicate the date of treatment at the end of this section.
- Yes  No Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
- Yes  No Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
- Yes  No Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
- Yes  No Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.
- Yes  No Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
- Yes  No Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.\*
- Yes  No Cancer or malignant tumors.
- Yes  No Have you received treatment or been hospitalized for any other condition than those listed above?
- 
- 2**  Yes  No Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
- 
- 3**  Yes  No Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
- 
- 4**  Yes  No Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking, and the condition for which the medication is prescribed.
- 
- 5**  Yes  No Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

Condition or medication	Date	Explanation/current status

\* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true and complete. I understand that coverage may be cancelled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

**Signature\*\***

**Date**



**\*\* Your signature is required in this section only if completing the Statement of Health.**

## Authorization for release of medical information

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By signing below you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

**Expiration:** This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

**Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

**If you qualify for guaranteed acceptance, do not sign this release.** (See the Guaranteed Acceptance section for qualifying information).

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**Signature**

**Date**



# Automatic Payment Authorization Form

## Medicare Supplement plans

- I am:**  a new automatic payment applicant  
 a current automatic payment user reporting a change in my credit card, bank or account number (please note this change requires 30 days for processing)

### Subscriber information

Subscriber name \_\_\_\_\_ Subscriber number \_\_\_\_\_  
Mailing address \_\_\_\_\_ Daytime phone number \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### Easy\$Pay – Checking or savings account debits

**Debit date:**  1<sup>st</sup> of month  15<sup>th</sup> of month

**Note: If you're requesting Easy\$Pay and you're sending a voided check or deposit slip, you don't need to complete the following.**

**Type of account:**  Checking  Savings

Bank routing/transfer number \_\_\_\_\_  
Bank account number \_\_\_\_\_  
Name of financial institution \_\_\_\_\_ Branch telephone number \_\_\_\_\_  
Name(s) on bank account \_\_\_\_\_  
Branch address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

### Credit card payments

**Please note: The \$2 savings only applies to the Easy\$Pay payments and does not apply to credit card payments.**

Type of account:  Visa  MasterCard  
Payment frequency:  Monthly charge  Quarterly charge

Credit card charge date must be on the first of the month.

Cardholder name \_\_\_\_\_  
Cardholder billing address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Credit card number \_\_\_\_\_ Expiration date (mm/yyyy) \_\_\_\_\_

### Authorization and signature(s)

#### Automatic payment by debit from checking/savings account:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record and I will be responsible for making my payment by check or money order, along with a return item service charge.

#### Automatic payment by credit card:

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to charge (and/or apply credits, if correcting errors to previous charges) the credit card identified on this form on the payment date and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I understand that charges may occur 1 to 2 days prior to the payment date indicated on this form. If the credit card transaction ever fails (e.g., over limit, expired), Blue Shield will mail a bill to me to my address on record and I will be responsible for making my payment by check or money order.

#### Notice to Change/Cancel Required:

I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days notice before a debit/charge, is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at (800) 248-2341. Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form, and I acknowledge that I have received a copy of this form (if the bank account is a joint account, all account holders must sign). I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.



Signature \_\_\_\_\_ Print name \_\_\_\_\_  
Social Security number \_\_\_\_\_ Date \_\_\_\_\_  
Signature \_\_\_\_\_ Print name \_\_\_\_\_  
Social Security number \_\_\_\_\_ Date \_\_\_\_\_

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE COVERAGE**

Blue Shield of California, 6300 Canoga Avenue, Woodland Hills, CA 91367

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

According to your application, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

**Statement to applicant by plan, solicitor, solicitor firm or other representative:**

- (1) I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):
  - Additional benefits
  - No change in benefits, but lower premiums or charges
  - Fewer benefits and lower premiums or charges
  - Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
  - Disenrollment from a Medicare Advantage plan
  - Reasons for disenrollment: Other (please specify): \_\_\_\_\_
- (2) If the issuer of the Medicare supplement contract being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
- (3) State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
- (4) If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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.
- (5) **Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.**



\_\_\_\_\_  
(Signature of Solicitor, Solicitor Firm, or Other Representative)

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Typed Name of Plan, Solicitor, or Solicitor Firm)

\_\_\_\_\_  
(Date – Month, Day, Year)

\_\_\_\_\_  
(Mailing Address of Plan, Solicitor's, or Solicitor's Firm)