**Producer Name**_____ **Producer Number**_____

Standard Life
And Casualty Insurance Company

**Administrative Office:**
**P.O. Box 14308, Clearwater, FL 33766-4308**
**(855) 406-9081**

# Application for Medicare Supplement Coverage

Applicant acknowledges and agrees that if there is more than one applicant on this application, all information provided may be viewed or shared with the other applicant.

**INCOMPLETE INFORMATION MAY DELAY PROCESSING.**

## SECTION 1: Plan/Premium Payment Information (to be completed by Producer)

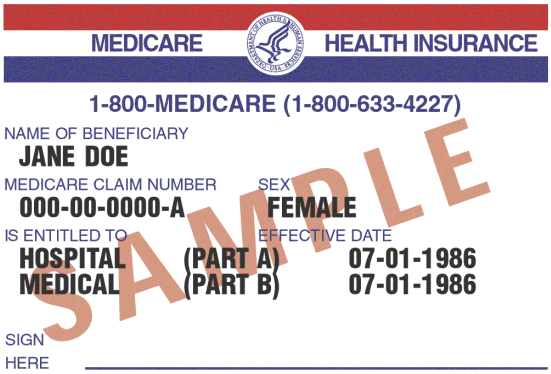
**NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.**

| **APPLICANT** | **APPLICANT B** |
|---|---|
| Medicare Supplement Plan Requested:<br>☐ A ☐ F ☐ G ☐ N | Medicare Supplement Plan Requested:<br>☐ A ☐ F ☐ G ☐ N |
| Requested Effective Date _____ | Requested Effective Date _____ |
| Mail Policy To: ☐ Insured ☐ Producer | Mail Policy To: ☐ Insured ☐ Producer |
| Calculated Premium (include app fee; HHD)<br>$ _____ + $ _____ - $ _____ = $ _____<br>premium app fee HHD total | Calculated Premium (include app fee; HHD)<br>$ _____ + $ _____ - $ _____ = $ _____<br>premium app fee HHD total |
| Select Premium Payment Option:<br>☐ Annual direct ☐ ACH Annual<br>☐ Semi-annual direct ☐ ACH Semi-annual<br>☐ Quarterly direct ☐ ACH Quarterly<br>☐ ACH Monthly (direct monthly not available) | Select Premium Payment Option:<br>☐ Annual direct ☐ ACH Annual<br>☐ Semi-annual direct ☐ ACH Semi-annual<br>☐ Quarterly direct ☐ ACH Quarterly<br>☐ ACH Monthly (direct monthly not available) |

## SECTION 2: Applicant Information – PLEASE ANSWER ALL QUESTIONS COMPLETELY.

| **Applicant** | **Applicant B** |
|---|---|
| Name (First/Middle/Last) | Name (First/Middle/Last) |
| Residence Address | Residence Address |
| City | City |
| State ZIP | State ZIP |
| Mailing Address (if different from residence address) | Mailing Address (if different from residence address) |
| City | City |
| State ZIP | State ZIP |
| Home Phone No (_____)_____ - _____<br>(area code) | Home Phone No (_____)_____ - _____<br>(area code) |
| Current Age _____ Date of Birth _____<br>mo/day/ yr | Current Age _____ Date of Birth _____<br>mo/day/ yr |
| ☐ Male ☐ Female State of Birth_____ | ☐ Male ☐ Female State of Birth_____ |
| Social Security No _____ | Social Security No _____ |
| E-mail Address | E-mail Address |
| Height: Ft _____ In _____ Weight: Lbs _____ | Height: Ft _____ In _____ Weight: Lbs _____ |
| Have you used tobacco in any form in the past 12 months?..... ☐ Yes ☐ No | Have you used tobacco in any form in the past 12 months?..... ☐ Yes ☐ No |

| SECTION 2: Applicant Information (continued) – PLEASE ANSWER ALL QUESTIONS COMPLETELY. | |
|---|---|
| Medicare Health Insurance Card Number (if known)<br>_____ _____ _____ _____ | Medicare Health Insurance Card Number (if known)<br>_____ _____ _____ _____ |




| SECTION 3: HOUSEHOLD PREMIUM DISCOUNT INFORMATION. | | |
|---|---|---|
| **You may be eligible for a policy with a lower premium rate based on your answers to the statements in this section.**<br>1. Does a member of your household with whom you have continuously resided for the last 12 months either have an existing Medicare supplement plan with, or are applying for coverage with Standard Life and Casualty?.....<br>2. If you answered "YES" to Question 1 above, please fill out the following information listing up to 3 people in your household, except if both applicants are applying for coverage on this application. | **Applicant**<br>☐ Yes ☐ No | **Applicant B**<br>☐ Yes ☐ No |
| Name (First/Middle/Last) | | |
| Policy Number | | |
| Street Address | | |
| City/State/Zip | | |
| Name (First/Middle/Last) | | |
| Policy Number | | |
| Street Address | | |
| City/State/Zip | | |
| Name (First/Middle/Last) | | |
| Policy Number | | |
| Street Address | | |
| City/State/Zip | | |

| SECTION 4: If Applying for Medicare Supplement Coverage, PLEASE ANSWER ALL QUESTIONS COMPLETELY. | | |
|---|---|---|
| Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**? | **Applicant**<br>☐ Yes ☐ No | **Applicant B**<br>☐ Yes ☐ No |
| **To the Best of Your Knowledge**:<br>1. Are you covered under Medicare Part A?<br>If "YES," what is your Part A effective date?_____/_____<br>Applicant Applicant B<br>If "NO," what is your eligibility date? _____/_____<br>Applicant Applicant B | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Are you covered under Medicare Part B?<br>If "YES," what is your Part B effective date?_____/_____<br>Applicant Applicant B<br>If "NO," indicate date you plan to enroll. _____/_____<br>Applicant Applicant B | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Will you turn 65within the next six months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Did you enroll in Medicare Part B in the last six months?<br>If "YES," indicate your effective date._____/_____<br>Applicant Applicant B | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Are you applying for coverage because you have been recently diagnosed with or are currently being treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis? | ☐ Yes ☐ No | ☐ Yes ☐ No |

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 certificate, or that you had certain rights to buy such a policy or certificate, 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 questions below.**

SECTION 5: FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

| To the Best of Your Knowledge: | **Applicant** | **Applicant B** |
|---|---|---|
| 1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (a) If "YES," with what company, and what plan do you have? | | |

| **Applicant** | **Applicant B** |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Plan | Plan |
| Issue Date / / | Issue Date / / |

| | | |
|---|---|---|
| (b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (c) If "YES," indicate termination date. _____ (Applicant) / _____ (Applicant B) | | |
| (d) **If "YES," have you received a copy of the replacement notice?** | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.**

| | | |
|---|---|---|
| 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_____ (Applicant) END_____ / START_____ (Applicant B) END_____ | | |
| (a) 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 | ☐ Yes ☐ No |
| (b) **If "YES," have you received a copy of the replacement notice?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B) | | |
| (d) Planned date of termination/disenrollment? _____ (Applicant) / _____ (Applicant B) | | |
| (e) Was this your first time in this type of Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (g) Is your former Medicare supplement or Medicare select policy/certificate still available? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (a) If "YES," with what company and what kind of policy/certificate? (List below.) | | |

| **Applicant** | | **Applicant B** | |
|---|---|---|---|
| Name of Company | Kind of Policy/Certificate | Name of Company | Kind of Policy/Certificate |
| | | | |

| | | |
|---|---|---|
| (b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. START_____ (Applicant) END_____ / START_____ (Applicant B) END_____ | | |
| (c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B) | | |
| (d) Planned date of termination/disenrollment? _____ (Applicant) / _____ (Applicant B) | | |
| 5. Are you covered for medical assistance through the state Medicaid program? (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.) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "YES," | | |
| (a) Will Medicaid pay your premiums for this Medicare supplement policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? | ☐ Yes ☐ No | ☐ Yes ☐ No |

| SECTION 5: FOR YOUR PROTECTION (Continued) | |
|---|---|
| 6. Producers shall list any other health insurance policies/certificates they have sold to the applicant.<br>(a) List policies/certificates sold which are still in force. | |
| **Applicant** | **Applicant B** |
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Description of Benefits | Description of Benefits |
| Effective Date of Coverage | Effective Date of Coverage |
| (b) List policies/certificates sold in the past five (5) years which are no longer in force. | |
| **Applicant** | **Applicant B** |
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Description of Benefits | Description of Benefits |
| Effective Date of Coverage | Effective Date of Coverage |

**If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 6 and GO TO SECTION 7.**

SECTION 6: PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-16, that person is not eligible for coverage.

| | Applicant | Applicant B |
|---|---|---|
| 1. Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Have you been diagnosed with or treated for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Have you been diagnosed with or treated for Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, or Cirrhosis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Have you been diagnosed with or treated for Chronic kidney disease, kidney failure, or kidney disease requiring dialysis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Have you been diagnosed with or treated for Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 7. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 8. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 9. Do you have an implanted cardiac defibrillator? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 10. Within the past two years have you been treated for degenerative bone disease, spinal stenosis, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 13. Have you been hospital confined three or more times in the last two years? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 14. Have you had an organ transplant or been advised by a physician to have an organ transplant? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 15. Do you have diabetes that has ever required more than 50 units of insulin daily? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 16. If you have diabetes, do you have any of the following conditions: retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), stroke, or kidney disease? If you do not have diabetes, this question should be answered "NO". | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 17. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 months? If "YES," please list the drug and the condition in the following table. | ☐ Yes ☐ No | ☐ Yes ☐ No |

SECTION 6: HEALTH /MEDICAL QUESTIONS (Continued)

| **Applicant** (please attach a separate sheet if needed) | | **Applicant B** (please attach a separate sheet if needed) |
|---|---|---|
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |

IF ADDITIONAL SPACE IS REQUIRED SEE PAGE 8

## SECTION 7: BILLING INFORMATION

***IMPORTANT:*** *When choosing to pay initial premium by Automated Bank Account Withdrawal,* ***THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY WHEN YOUR POLICY IS ISSUED.***

**I would like my monthly premium payment to come from my (check one) on the _____ day of the month:**

☐ **Checking** (**Please attach a voided check.)** ☐ **Savings** (**Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.)**

| Financial Institution Name: | Phone #: |
|---|---|
| Financial Institution Address: | |
| Transit Routing #: | Account #: |

I hereby request and authorize Standard Life and Casualty Insurance Company (Standard Life and Casualty) to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Standard Life and Casualty or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Standard Life and Casualty's rights in respect to each charge shall be the same as if it were a check made payable to Standard Life and Casualty and personally signed by me. If any charge is dishonored for any reason, Standard Life and Casualty shall not be under any liability even though such dishonor results in the forfeiture of insurance.

| | |
|---|---|
| Signature as it appears on financial institution records | Print name of account owner (if other than applicant) |
| Date | Relationship of account owner to applicant |

## SECTION 8: PLEASE READ AND SIGN BELOW

**IMPORTANT STATEMENTS TO BE READ BY APPLICANT**

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the 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 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.
- 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.
- 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).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Standard Life and Casualty Insurance Company.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.**

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed. I understand that I have the right to receive a copy of this Authorization and Acknowledgment.

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant B's Signature (if applying)

**Premium Must Accompany Application**
I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_____
(Signature of Licensed Producer)

_____
PRODUCER NUMBER / (STAMP)

| ADDITIONAL INFORMATION: SECTION 6 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #17 | | |
|---|---|---|
| **Applicant** (please attach a separate sheet if needed) | | **Applicant B** (please attach a separate sheet if needed) |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |
| | Medication Name (copy off pharmacy label) | |
| | Date **Originally** Prescribed | |
| | Frequency and Dosage | |
| | Diagnosis/Condition | |

| SECTION FOR ADDITIONAL COMMENTS | |
|---|---|
| **Applicant** (please attach a separate sheet if needed) | **Applicant B** (please attach a separate sheet if needed) |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |