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Medicare Supplement Underwriting Guidelines

November 1, 2020

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***Please Note: any changes from the previous version are highlighted in pale orange.
Specific State language is subject to change.
Current State Availability can be found on the agent portal.***

CONTACTS

CORRESPONDENCE

FAX Number for New Business – ACH Applications 1-866-545-8076

Any correspondence that cannot be submitted electronically should be sent to the addresses below:

Administrative Office Mailing Information

Mailing Address

Combined Insurance Company of America
P.O. Box 14207
Clearwater, FL 33766-4207

Overnight/Express Address

Combined Insurance Company of America
2650 McCormick Drive
Clearwater, FL 33759

Administrative Office – Questions

1-855-278-9329

INTRODUCTION

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare Supplement insurance policies. This manual provides the agent with information needed to identify...with a high degree of accuracy...those risks that are acceptable and those that are not. When used correctly, the underwriting guidelines can have a dramatic effect on your issue rate and quality rating. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. To ensure we accomplish this goal, the producer or applicant will be contacted directly by underwriting if there are any issues with an application.

UNDERWRITING AND ITS IMPORTANCE

Underwriting is a critical factor when determining whether or not to issue Health insurance because it protects not only the financial health of the insurance company and the agent, but also the financial well-being of the insured. Underwriting is the primary process used to determine how much risk a proposed insured represents. To examine this risk, the underwriter must gather information relating to the individual who is applying for coverage.

The first step of the underwriting process is field underwriting. Field underwriting is the process of gathering initial information about a proposed insured and screening those individuals to determine if they qualify to have an application submitted for a specific type of coverage. **Field underwriting is when an agent makes a preliminary assessment of the insurability of the applicant and determines whether an application can be submitted to the Home Office for consideration.** In addition, the agent consults the underwriting guidelines which contain specific rules with respect to medical conditions and medications.

Home Office underwriting begins when the completed application is screened by the underwriter. The insurance application is the primary source of information for an underwriting decision. The agent's responsibility is to verify that the application is complete and as accurate as possible. In addition to the application the underwriter may request a personal history (telephone) interview or order a pharmacy report and/or medical records in making a final decision. Underwriting has to weigh the significance of any impairment(s) individually or together to determine what type of risk is presented.

MACRA

Plan Changes under the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA") – Effective January 1, 2020

MACRA - Medicare Access and CHIP Reauthorization Act of 2015 - is the largest scale change to the American health care system following the Affordable Care Act in 2010. First, MACRA requires the removal of Social Security Numbers from all Medicare cards to better protect individual's private financial information. This will be accomplished by the end of 2019.

Starting January 1, 2020, Medigap plans sold to new people with Medicare will not be allowed to cover the Part B deductible. Because of this, Plans C and F will no longer be available to individuals new to Medicare starting on January 1, 2020. If a person already has either of these 2 plans (or the high deductible version of Plan F) or are covered by one of these plans before January 1, 2020, he/she will be able to keep that plan. If a person is eligible for Medicare before January 1, 2020, but not yet enrolled, he/she may still be able to buy one of these plans.

This means that agents need to verify when the individual client became Medicare-Eligible:

- Individuals born on December 31, 1954 or before - become eligible for Medicare before January 1, 2020 - and have a right to purchase a Medicare Supplement Plan C or Plan F.
- Individuals born on January 1, 1955 or after - become eligible for Medicare on or after January 1, 2020 - and cannot purchase a Medicare Supplement Plan C or Plan F.

It is imperative that agents address this issue before completing the application for Medicare Supplement because CMS plans to impose penalties for any policy that is issued incorrectly.

The following chart displays what is covered under the various plans and who is eligible for which plans:

Benefits	Plans Available to All Applicants								Plans Available ONLY to those first eligible before 01/01/2020	
	A	B	D	G / G ¹	K	L	M	N	C	F / F ¹
Medicare Part A coinsurance and hospital coverage (up to an additional 365 days after Medicare benefits are used up)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Medicare Part B coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
							✓	copays apply ³		
Blood (first three pints)	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Part A hospice care coinsurance or copayment	✓	✓	✓	✓	50%	75%	✓	✓	✓	✓
Skilled nursing facility coinsurance			✓	✓	50%	75%	✓	✓	✓	✓
Medicare Part A deductible		✓	✓	✓	50%	75%	50%	✓	✓	✓
Medicare Part B deductible									✓	✓
Medicare Part B excess charges				✓						✓
Foreign travel emergency (up to plan limits)			✓	✓			✓	✓	✓	✓
Out-of-pocket limit in [2019] ²					[\$5560] ²	[\$2780] ²				

¹Plans F and G also have a high deductible option which require first paying a plan deductible of \$[2300] before the plan begins to pay. Once the plan deductible is met, the plan pays 100% of covered services for the rest of the calendar year. High deductible plan G does not cover the Medicare Part B deductible. However, high deductible plans F and G count your payment of the Medicare Part B deductible toward meeting the plan deductible.

²Plans K and L pay 100% of covered services for the rest of the calendar year once you meet the out-of-pocket yearly limit.

³Plan N pays 100% of the Part B coinsurance, except for a copayment of up to \$20 for some office visits and up to a \$50 copayment for emergency room visits that do not result in an inpatient admission.

KEYS TO GETTING POLICIES ISSUED

When completing the application make sure that all information is recorded accurately and is legible. Alterations on the application may cause the need for a telephone interview. Specifically, watch for alterations of height and weight, medications, medical conditions and medical questions.

If an applicant has not seen a doctor in the last 5 years please indicate this in the section under the medical questions.

Make sure you obtain all appropriate signatures before submitting the application.

Make sure you include all required State specific forms.

Follow the established height and weight, medications and medical conditions guidelines as outlined in the manual.

Inform the applicant that the underwriting department may call them to conduct a telephone interview to review relevant information on the application. Telephone interviews are conducted from 8:00 AM - 6:00 PM Eastern Standard Time.

Always note on the application the best time to call. Ask the applicant if it is OK to contact them at work or on their cell phone. If so, please provide the number(s) and indicate that it is OK for us to contact them at either number.

WHAT AN AGENT SHOULD ALWAYS ASK

The agent is the first contact with the applicant and becomes the “eyes and ears” of underwriting. In order to understand the health conditions of the applicant and to accurately communicate the conditions to the underwriter, the agent should always inquire and add to the application any notes concerning:

- If any medical conditions are admitted to on the application:
 - What is the current status?
 - Are there any current symptoms?
 - What is the current treatment?
 - Are there any complications?
 - Is the condition under evaluation or has surgery been recommended?
 - Does the applicant take all medication as prescribed by his/her physician?
 - Is the applicant compliant with all other methods of treatment (ie lifestyle changes, therapeutic regimens) as recommended by his/her physician?
- Are they scheduled to see their physician in the next 6 months? Explain.
- Do they have regular checkups? If so, when was the last check-up and what were the results?
- Have they had any surgeries in the last 24 months, or have they been recommended to have surgery? Explain.
- Have they undergone any diagnostic testing in the last 12 months or been recommended by a physician to do so? Explain.
- Receiving disability benefits in the past 12 months or has applied for disability benefits? Explain.
- Are they on Medicaid?

TIPS FOR COMPLETING THE APPLICATION

ALWAYS

- Ask each question exactly as written (do not paraphrase).
- Record each answer exactly as given.
- Complete the application legibly and in black ink.
- Draw a line through any errors and have the applicant initial and date corrections.

The issue state and the residence state must be based on the applicant. The residence state is determined by the state in which the applicant files federal income tax statements. Agents must be appointed in the state where the application is signed.

All agents must also use the current application packet for the insured's resident state at the time of application. Applications received for processing that are based on the agent's issue state and not the applicant's resident state will be returned.

Applications must be submitted within thirty (30) days of the signed application date and cannot have a requested effective date prior to the date the application is signed.

For underwritten and Guaranteed Issue applications, the requested effective date may not be more than sixty (60) days from the date the application was signed.

Initial full modal premium or signed Pre-Authorized Electronic Fund Transfer (EFT) form must be submitted with all applications.

Payer/payee guidelines: We will not accept premium payments from an employer or a group. Each policy is an individual contract. Premium payments will be accepted only from the policyholder or an immediate family member. No third-party payers will be accepted.

If applicable, all state-required forms (e.g., replacement, state disclosure and disenrollment / termination letter) should accompany the application at the time of submission.

Follow the established height and weight, medications and medical conditions guidelines as outlined in the manual.

Make sure you obtain ALL appropriate signatures before submitting the application.

We do not accept stamped or electronic signatures from either agents or applicants.

NEVER

- Use "white out" or similar substances for corrections or mistakes.
- Tell or suggest to the applicant how he or she should answer a question.
- Ask a general question (e.g. "Are you in good health?"), then mark all of the medical questions on the application as "No".
- Allow someone other than the applicant to answer the application questions.

POLICY ISSUE GUIDELINES

All applicants must be covered under Medicare Part A and B on the effective date of the policy. Policy issue is state specific. The applicant's state of residence controls the application, forms, premium and policy issue. If an applicant has more than one residence, the state where taxes are filed should be considered as the state of residence. Please refer to the introductory materials you received for any required forms specific to your state.

OPEN ENROLLMENT

To be eligible for open enrollment, an applicant must be turning 65 years of age (in most states) and be within six months of his/her enrollment in Medicare Part B.

Applicants in the state of Florida who are 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, and who are enrolled in Medicare Part B, and who reside in this state, will be considered for Open Enrollment upon the request of the individual during the 2-month period following termination of coverage under a group health insurance policy.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month open enrollment period upon reaching age 65. Coverage could be effective the earliest of the first of the month in which the applicant is turning 65 or thereafter. Applications may be submitted up to 60 days prior to the requested effective date.

During this period, we cannot deny insurance coverage, place conditions on a policy or charge more premium due to past medical conditions. Proof of coverage under Medicare Part B is required for applicants who are outside the six months of enrollment in Medicare when turning 65. This includes individuals who have postponed enrollment in Medicare Part B at age 65 as well as applicants who are under age 65 and qualify due to disability. Proof of coverage under Medicare Part B includes either a copy of the Medicare Card or the letter from CMS acknowledging when medical benefits begin under Medicare. Proof of the Open Enrollment right needs to be submitted with the application.

Some states require that Medicare supplement open enrollment be offered to individuals under age 65. Refer to the chart below for details.

States with Under Age 65 Requirements—All plans may not be available in all states		
The following states require that Combined Insurance offer coverage to applicants under age 65; in ALL other states, applicants under age 65 are NOT eligible for coverage		
State	Under Age 65 Accepted	Plans Available
Colorado, Illinois, New Jersey, South Carolina, Texas	Combined Insurance Company has made the recent decision to discontinue offering a Medicare supplement product in Colorado, Illinois, New Jersey, South Carolina and Texas effective December 1, 2019.	
California	Yes, O/E if applied for within six months of Part B enrollment. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the "Federal Open Enrollment Period" when the applicant turns age 65. Not available for individuals with End Stage Renal Disease.	All plans sold are available – (A, F, G, N)
Connecticut	Yes.	Plan A is available
Florida	Yes, O/E if applied for within six months of Part B enrollment or within the first two months after termination of group health coverage. Applications submitted outside of the Open Enrollment period will be subject to the same underwriting criteria used for applicants who are 65 or older and outside of the Open Enrollment period.	All plans sold are available – (A, F, G)

States with Under Age 65 Requirements—All plans may not be available in all states

The following states require that Combined Insurance offer coverage to applicants under age 65; in ALL other states, applicants under age 65 are NOT eligible for coverage

State	Under Age 65 Accepted	Plans Available
Georgia	Yes, O/E if applied for within six months of Part B enrollment. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65. Retroactive enrollment allowed when due to a retroactive eligibility decision made by the SSA.	All plans sold are available – (A, G)
Indiana	Yes, O/E if applied for within six months of Part B enrollment. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.	Plan A is available
Kansas	Yes, O/E if applied for within six months of Part B enrollment. If applying outside this Open Enrollment period, the application is subject to underwriting & must qualify medically.	All plans sold are available – (A, F, G)
Kentucky	No Open Enrollment. All applications are underwritten. Always use Non-Tobacco rates.	All plans sold are available – (A, F, G, N)
Louisiana, South Dakota, Tennessee	Yes, O/E if applied for within six months of Part B enrollment. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.	All plans sold are available – (A, F, G, N)
Mississippi	Yes, O/E if applied for within six months of Part B enrollment. If applying outside this Open Enrollment period, the application is subject to underwriting & must qualify medically.	Plans A, F and N are available
Missouri	Yes, O/E if applied for within six months of Part B enrollment. If applying outside this Open Enrollment period, the application is subject to underwriting & must qualify medically.	All plans sold are available – (A, F, G, N)
Montana	Yes, O/E if applied for within six months of Part B enrollment. If applying outside this Open Enrollment period, the application is subject to underwriting & must qualify medically. O/E also applies during the 63-day period following termination of coverage under a group or individual health insurance policy or certificate for a person enrolled, or eligible for enrollment in Medicare Part B.	All plans sold are available – (A, F, G, N)
North Carolina	Yes, O/E if applied for within six months of Part B enrollment. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.	Plans A, F and G are available

States with Under Age 65 Requirements—All plans may not be available in all states

The following states require that Combined Insurance offer coverage to applicants under age 65; in ALL other states, applicants under age 65 are NOT eligible for coverage

State	Under Age 65 Accepted	Plans Available
Oklahoma	Yes, O/E if applied for within six months of Part B enrollment. If applying outside this O/E period, the application is subject to underwriting & must qualify medically.	Plan A is available
Pennsylvania	Yes, O/E if applied for within six months of Part B enrollment. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.”	All Plans sold are available – (A, B, F, G and N)
<p>† Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.</p>		

UNDER AGE 65 ESRD (END STAGE RENAL DISEASE) REQUIREMENTS

The following states require us to offer Medicare Supplement coverage, without medical underwriting to individuals under age 65 and on Medicare disability due to End Stage Renal Disease (ESRD):

- Connecticut – only Plan A is available.
- Florida – All Plans (A, F, G) †. The open enrollment period is within the first 6 months after the effective date of Medicare Part B or during the 2-month period following termination of coverage under a group health insurance policy. Premium rates for ESRD are the same as the under age 65 disabled premium rates.
- Georgia – All Plans (A, F, G and N) † are available. Open enrollment if applied for within six months of Part B enrollment. There are distinct premium rates for this coverage. Retroactive enrollment allowed when due to a retroactive eligibility decision made by the SSA.

The open enrollment period is within the first 6 months after the effective date of Medicare Part B. Applications written outside this open enrollment period will be declined and premium will be refunded.

† Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.

GENERAL UNDERWRITING INFORMATION

Applicants over the age of 65, or under age 65 in the states listed and specified in the chart above, and at least six months beyond enrollment in Medicare Part B will be underwritten. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. Applicants will be accepted or declined. Applications signed by a Power of Attorney will not be accepted for Selective (Underwritten) Issue.

If the Application is signed by a Power of Attorney, a properly signed and executed Power of Attorney document must be submitted with the application. Specifically, the document should give the Power of Attorney the following authorities:

- Financial/Banking authority – allows the POA to conduct financial transactions (pay premium)
- Insurance authority – allows the POA to enter into insurance contracts (sign application)
- Healthcare authority – allows the POA to make decisions and discuss healthcare issues

There may be additional items that will need to be verified. For example, if more than one person is given the Power of Attorney, is there a given order as to who is first? If the first person named is not the person who signed the application, why is the first person named not serving as the POA? When is the POA to be effective? If the POA will become effective upon written certification of disability or mental incompetence, then we would need a copy of the written certification of disability or lack of competence. We will not be able to process an application that is signed by a Power of Attorney without the proper documentation and explanations needed.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Coverage will be declined for those applicants who are outside the established height and weight guidelines.

Health information, including answers to health questions on applications and claims information, is confidential and is protected by state and federal privacy laws. Accordingly, Combined Insurance Company of America does not disclose health information to any non-affiliated insurance company without authorization.

APPLICATION DATES

- **Open Enrollment** – Up to six months prior to enrollment in Medicare Part B.
- **Underwritten Cases** – Up to 60 days prior to the requested coverage effective date.
- **Individuals** – Individuals whose employer group health plan coverage is ending can apply up to 3 months prior to the requested effective date of coverage.
- **West Virginia** – applications may be taken up to 90 days prior to the effective date of their Medicare eligibility due to age.

COVERAGE EFFECTIVE DATES

Coverage will be made effective as indicated below:

- 1). Between age 64½ and 65 – The first of the month the individual turns age 65.
- 2). All Others – Application date or date of termination of other coverage, whichever is later.
- 3). Effective date cannot be the 29th, 30th, or 31st of the month.

REPLACEMENTS

A “replacement” takes place when an applicant terminates an existing Medicare Supplement/Select or Medicare Advantage policy and replaces it with a new Medicare Supplement policy. Combined Insurance Company of America requires a fully completed application when applying for a replacement policy (both internal and external replacements). Application fee should be included with all new applications.

A policy owner wanting to apply for a non-tobacco Plan must complete a new application and qualify for coverage.

If an applicant has an existing Medicare Supplement, Medicare Select or Medicare Advantage policy, any new application will be considered to be a replacement application. All replacement applications will be underwritten.

All replacements involving a Medicare Supplement, Medicare Select or Medicare Advantage Plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application. The replacement cannot be applied for on the exact same coverage and exact same company.

The replacement Medicare Supplement policy cannot be issued in addition to any other existing Medicare Supplement, Select or Medicare Advantage Plan.

REINSTATEMENTS

When a Medicare Supplement policy has lapsed and it is within 90 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements. The agent's commission rates will continue based on the policy's duration. When a Medicare Supplement policy has lapsed and it is more than 90 days beyond the last paid to date, the coverage cannot be reinstated. The client may, however, apply for new coverage. All underwriting requirements must be met before a new policy can be issued.

TELEPHONE INTERVIEWS

Random telephone interviews with applicants will be conducted on underwritten cases. Please be sure to advise your clients that we may be calling to verify the information on their application.

PHARMACEUTICAL INFORMATION

Combined Insurance Company of America has implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. In order to obtain the pharmaceutical information as requested, please be sure to include a completed "Authorization to Release Confidential Medical Information (HIPAA)" form with all underwritten applications. This form can be found in the Application Packet. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This additional information will not be solely used to decline coverage.

POLICY DELIVERY RECEIPT

Based on state specific requirements, a policy delivery receipt may be required. If a policy delivery receipt is required, it will be included in the policy package and a copy must be returned to our New Business office.

GUARANTEED ISSUE RIGHTS

If the applicant(s) falls under one of the Guaranteed Issue situations outlined below, proof of eligibility must be submitted with the application. Proper proof of GI Rights include:

- a letter of creditable coverage from the previous carrier, or
- a letter from the applicant's employer.

The situations listed below can also be found in the Guide to Health Insurance.

Guaranteed issue situation	Client has the right to buy
<p>Client is in the original Medicare Plan and has an employer group health Plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending.</p> <p>In Florida, the employer group plan terminates or ceases to provide at least the minimum benefits provided by a Plan A Medicare Supplement policy.</p> <p>Note: In this situation, state laws may vary.</p>	<p>Medigap Plan A, B, C, F (including high deductible F), K or L that is sold in client's state by any insurance company. †</p> <p>If client has COBRA coverage, client can either buy a Medigap policy/certificate right away or wait until the COBRA coverage ends.</p>
<p>Required supporting documentation could be a dated letter from either the employer or group carrier including the Client's name, type of coverage, coverage-end date, and termination reason.</p>	

Guaranteed issue situation	Client has the right to buy
<p>Client is in the original Medicare Plan and has a Medicare SELECT policy/certificate. Client moves out of the Medicare SELECT Plan's service area.</p> <p>Client can keep the Medigap policy/certificate or he/she may want to switch to another Medigap policy/certificate.</p> <p>In Florida, client is enrolled in a MEDICARE COST plan (or similar plan effective prior to April 1, 1999); or a HEALTH CARE PREPAYMENT plan. That coverage is ending through no fault of the client or because the client is moving out of the coverage area.</p>	<p>Medigap Plan A, B, C, F (including high deductible F), K or L that is sold by any insurance company in client's state or the state he/she is moving to. †</p>
<p>Required supporting documentation could be a dated letter from the SELECT carrier including the Client's name, type of coverage, coverage-end date, and termination reason.</p>	
<p>Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy/certificate coverage otherwise ends through no fault of the client.</p>	<p>Medigap Plan A, B, C, F (including high deductible F), K or L that is sold in client's state by any insurance company. †</p>
<p>Required supporting documentation could be a dated letter from the carrier including the Client's name, type of coverage, coverage-end date, and termination reason.</p>	
<p>Client is in the original Medicare Plan and has a Medicare SUPPLEMENT policy/certificate and wants to terminate that coverage because the company substantially violated a material provision of the policy or the company or agent has materially misrepresented the policy's provisions and misled the client.</p>	<p>Medigap Plan A, B, C, F (including high deductible F), K or L that is sold in the client's state by any insurance company. †</p>
<p>Required supporting documentation is a dated letter from CMS confirming that the client was misled and the effective date that the Medicare Supplement Plan has been terminated.</p>	
<p>In Florida, client enrolls in a Medicare Prescription D plan during the initial enrollment period and terminates a Medicare SUPPLEMENT policy/certificate that covers outpatient prescription drug coverage. Client submits evidence of enrollment in Medicare Part D.</p>	<p>The same policy available from the same company modified to remove the outpatient prescription drug coverage; or Medigap Plan A, B, C, F (including high deductible F), K or L that is offered by any insurance company. †</p>
<p>Required supporting documentation could be a dated letter from the carrier including the Client's name, type of coverage, coverage-end date, and termination reason.</p>	
<p>† Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.</p>	

Generally, the Guaranteed Issue period lasts for 63 days from when the coverage terminates. This period may vary by state regulations.

LOSS OF MEDICAID QUALIFICATION RIGHTS

State	Situation	Client has the right to buy
CA	Applicant is enrolled in Medicare Part B and, as a result of an increase in income or assets, is no longer eligible for Medi-Cal benefits; or is only eligible for Medi-Cal benefits with a share cost and certifies at the time of application that they have not met the share of cost. Open Enrollment beginning with notice of termination and ending six months after the termination date.	<p><u>65 years or older</u> Any Medigap plan offered by any Issuer. †</p> <p><u>Under Age 65</u> Plans A and F. Not available for individuals with end stage renal disease. †</p>
KS	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Any Medigap plan offered by any issuer. †
TN	<p>Client age 65 and older is covered under Medicare Part B, is enrolled under Medicaid (TennCare), and the enrollment involuntarily ceases. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.</p> <p>Client under age 65 losing Medicaid (TennCare) coverage has a six month Open Enrollment period beginning on the date of involuntary loss of coverage.</p>	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer. †
<p>† Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F</p>		

GROUP HEALTH PLAN PROOF OF TERMINATION

Proof of Involuntary Termination: If applying for Medicare Supplement, Underwriting cannot issue coverage as Guaranteed Issue without proof that an individual's group coverage is no longer offered. The following is required: Complete the Other Health Insurance section on the Medicare Supplement application; and provide a copy of the termination letter; showing date of and reason for termination, from the group carrier.

Proof of Voluntary Termination: Unless required by state law or regulation, we will NOT offer coverage on a guaranteed issue basis to enrollees who voluntarily terminate coverage under a group welfare benefit plan (or intend to do so) prior to applying for coverage under a Combined Insurance Medicare Supplement plan. Under the state specific voluntary terminations scenarios, the following proof of termination is required along with completing the Other Health Insurance section on the Medicare Supplement application:

- Certificate of Group Health Plan Coverage – In OK and WV, provide proof of change in benefits from employer or group carrier.

GUARANTEED ISSUE RIGHTS FOR VOLUNTARY TERMINATION OF GROUP HEALTH PLAN

State	Qualifies for Guaranteed Issue...
CA	If the employer sponsored plan's benefits are reduced, with Part B coinsurance no longer being covered.
FL	Any individual who is 65 years of age or older, or under 65 years of age and eligible for Medicare by reason of a disability or end-stage renal disease, who is enrolled in Medicare Part B, and who resides in Florida, upon the request of the individual during the 2-month period following termination of coverage under a group health insurance policy.
IN, MT, OH, PA	If the employer sponsored plan is primary to Medicare.
OK, WV	If the employer sponsored plan's benefits are reduced substantially.
KS, LA, MO, SD	No conditions – Always qualifies.

For purposes of determining GI eligibility due to a Voluntary Termination of an employer sponsored group welfare plan, a reduction in benefits will be defined as any increase in the insured's deductible amount or their coinsurance requirements (flat dollar co-pays or coinsurance %). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for GI eligibility. This definition will be used to satisfy OK and WV requirements. Proof of coverage termination is required.

OE / GI RIGHTS UNDER BIRTHDAY RULE OR ANNIVERSARY RULE REQUIREMENTS

Certain states require an Open Enrollment or Guaranteed Issue period around either an applicant's birthday or policy anniversary. The new policy will be issued without medical underwriting if the applicant is moving to a plan with equal or lesser benefits than the policy he/she is terminating.

The opportunity to switch policies on an Open Enrollment or Guaranteed Issue basis begins annually based on the applicant's birthday or the applicant's policy anniversary.

Indicate "Birthday or Anniversary Guaranteed Issue" in the medical section of the application.

The applicant must provide documentation confirming which Standard Plan he/she is terminating in order to demonstrate that the Standard Plan being applied for provides equal or lesser coverage than the plan being terminated. A replacement form is required.

To determine if the applicant qualifies for this Guaranteed Issue window:

State	Application Window	Eligibility Verification
California	60 days, beginning 30 days before and ending 60 days after the individual's birthday	<p>Applicant can purchase any Medicare Supplement policy that offers benefits equal to or lesser than the current inforce coverage. The only exception is if the applicant wants to purchase Plan G when moving from Plan F. This exception is subject to change at the company's discretion. Coverage will NOT be made effective PRIOR to the individual's birthday. To confirm eligibility, the applicant must provide:</p> <p>(1) proof of current plan – a copy of ID card or schedule page from the current coverage;</p> <p>(2) proof that coverage is in-force – a copy of renewal notice or billing notice; and</p> <p>(3) proof of birth date/residency – a copy of Driver's License or state ID showing date of birth; if Driver's License is not CA, provide something showing residency in state, e.g. copy of property tax notice, utility bill.</p> <p>A copy of the required birthday notice from the current carrier could provide all of the above.</p> <p>Premium will be the premium at the applicant's new age.</p>

Please be aware that we process Birthday Rule applications as follows:

- Applications can be signed and submitted up to 30 days before the applicant's birthday and no more than 30 days after the birthday.
- The requested effective date can be on the applicant's birthday and no more than the 1st of the month following 60 days after the birthday.
- For example, an applicant has a birthday of 02/08:
 - We will accept an application signed/dated and submitted before the birthday as early as 01/08 and the requested effective date could be on the birthday or as late as 03/01; or
 - We will accept an application signed/dated and submitted after the birthday but no later than 04/08 and the requested effective date could be on the signature date of the application or as late as 1st of the month following the signature date.

State	Application Window	Eligibility Verification
Missouri	Must apply no sooner than 60 days before and no later than 30 days after their policy anniversary date	To confirm eligibility, the applicant must provide: (1) proof of current plan and anniversary – a copy of the schedule page or application from the current coverage; (2) proof that coverage is in-force – a copy of renewal notice or billing notice.

Please be aware that we process Anniversary Rule applications as follows:

- Applications can be signed and submitted up to 60 days before the anniversary and no more than 30 days after the anniversary.
- The requested effective date can be 30 days before the anniversary and no more than 30 days after the anniversary.
- The requested effective date cannot precede the signature date of the application.
- For example, for an anniversary date of 02/01:
 - We will accept an application signed/dated and submitted before the anniversary as early as 12/01 and the requested effective date could be as early as 01/01 or as late as 02/01; or
 - We will accept an application signed/dated and submitted after the anniversary no later than 03/01 and the requested effective date could be as late as 03/01.

MEDICARE ADVANTAGE (“MA”)

MEDICARE ADVANTAGE (“MA”) ANNUAL MEDICARE PART C ELECTION PERIOD

General Election Periods for	Timeframe	Allows for
Annual Election Period (“AEP”)	Oct. 15th – Dec. 7th of every year	<ul style="list-style-type: none"> • Enrollment selection for MA (Part C) • Disenroll from a current MA Plan • Enrollment selection for Medicare Part D Prescription Drug Coverage
Medicare Advantage Open Enrollment Period (OEP)	Jan. 1st – Mar. 31st of every year	<p>Individuals enrolled in an MA plan, including newly MA-eligible individuals, to make a one-time election to go to another MA plan or return to Original Medicare. Individuals using the OEP to make a change may make a coordinating change to add or drop Part D coverage.</p> <p>The MA OEP does not provide an opportunity to switch from original Medicare to a Medicare Advantage Plan.</p> <p>The Medicare Advantage Open Enrollment Period is <i>not</i> synonymous with the Open Enrollment Period provided for Medicare Supplement Plans.</p>

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local State Health Insurance Assistance Program (SHIP) office for direction.

MEDICARE ADVANTAGE PROOF OF DISENROLLMENT

If applying for a Medicare Supplement, Underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare Advantage, the MA Plan must notify the member of his/her Medicare Supplement guaranteed issue rights.

Voluntarily disenrolling during AEP or OEP and not eligible for Guaranteed Issue

The section concerning the Medicare Advantage program should be answered completely:

- Stating when the Medicare Advantage program started;
- Leaving the “END” date blank, since the applicant is still covered;
- Confirming the applicant’s intent to replace the current MA coverage with this new Medicare Supplement policy;
- Confirming the receipt of the replacement notice;
- Stating the reason for the termination/disenrollment;
- Completing the planned date of termination/disenrollment;
- Specifying whether this was the first time in this type of Medicare plan (MA);
- Specifying whether there had been previous Medicare Supplement coverage; and
- Answering whether that previous Medicare Supplement coverage is still available.

If the applicant is applying during the Medicare Advantage Annual Enrollment Period (AEP), and all of the above information is provided, we will **NOT** require proof of termination from the Medicare Advantage provider. ***It is the applicant's responsibility to disenroll from the Medicare Advantage coverage during either the AEP or OEP.*** Please note that the CMS guidelines Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare advises that if the client joins a Medicare Advantage Plan, he/she cannot be sold a Medigap policy unless the coverage under the Medicare Advantage Plan will end before the effective date of the Medigap policy.

If an individual is requesting Guaranteed Issue or disenrolling outside AEP/OEP

1. The section concerning the MA program should be answered completely, as stated above; and
2. Send a copy of the applicant's MA Plan's disenrollment/termination notice with the application. This is especially important if the applicant is claiming a Guaranteed Issue right based on any situation as outlined in the CMS guidelines Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

Please note: All plans are not available as Guaranteed Issue in most situations.

For any questions regarding MA disenrollment eligibility, contact your SHIP office or call 1-800- MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

GUARANTEED ISSUE RIGHTS

The situations listed below can also be found in the Guide to Health Insurance. Along with the situations described below for a Medicare Advantage Plan, the state of Florida also extends Guaranteed Issue Rights to individuals who are 65 years of age or older and enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, where there are circumstances similar to those described below that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

Guaranteed issue situation	Client has the right to
Client's MA Plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the Plan's service area	Buy a Medigap Plan A, B, C, F (including high deductible F), K or L that is sold in the client's state by any insurance company. Client must switch to original Medicare Plan. †
Required supporting documentation could be a dated letter from the MA carrier including the Client's name, coverage-effective date, coverage-end date, and termination reason.	
Client joined a MA Plan when first eligible and, within the first year of joining, decided to switch back to original Medicare	Buy any Medigap Plan that is sold in his/her state by any insurance company. †
Required supporting documentation could be a dated letter from the MA carrier including the Client's name, coverage-effective date, coverage-end date, and termination reason.	
Client dropped his/her Medigap policy/certificate to join an MA Plan for the first time; in Florida, this would include a MEDICARE COST plan or PACE or a MEDICARE SELECT policy. Client has been in the Plan less than 1 year and wants to switch back.	Obtain client's Medigap policy/certificate back if that carrier still sells it. If his/her former Medigap policy/certificate is not available, the client can buy a Medigap Plan A, B, C, F (including high deductible F), K or L that is sold in his/her state by any insurance company. †
Required supporting documentation could be a dated letter from the previous Medicare Supplement carrier including the Client's name, plan, and coverage-end date, along with a statement that this plan is no longer available. A dated letter from the MA carrier including the Client's name, coverage-effective date and coverage-end date may also be required.	
Client is in an MA Plan and wants to terminate that coverage because the company substantially violated a material provision of the policy or the company or agent has materially misrepresented the policy's provisions and misled the client.	Buy Medigap Plan A, B, C, F (including high deductible F), K or L that is sold in the client's state by any insurance company. †
Required supporting documentation is a dated letter from CMS confirming that the client was misled and the effective date that the MA Plan has been terminated.	
<p>† Note: Plans C and F will no longer be available to people who are new to Medicare on or after January 1, 2020. However, if you were eligible for Medicare before January 1, 2020 but not yet enrolled, you may be able to buy Plan C or Plan F. People eligible for Medicare on or after January 1, 2020 have the right to buy Plans D and G instead of Plans C and F.</p>	

Generally, the Guaranteed Issue period lasts for 63 days from when the coverage terminates. This period may vary by state regulations.

PREMIUM

CALCULATING PREMIUM

Utilize Outline of Coverage

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if tobacco or non-tobacco use (*tobacco use includes use of electronic cigarettes and vaping*)
- Find age/gender - Verify that the age and date of birth are the exact age as of the effective date
- This will be your base monthly premium

Non-tobacco rates apply in certain states during open enrollment and guaranteed issue situations. See the Rate Type Available by State chart on the next page for state-specific information.

TYPES OF MEDICARE POLICY RATINGS

- **Community rated** – The same monthly premium is charged to everyone who has the Medicare policy, regardless of age. Premiums are the same no matter how old the applicant is. Premiums may go up because of inflation and other factors, but not based on age.
- **Issue-age rated** – The premium is based on the age the applicant is when the Medicare policy is bought. Premiums are lower for applicants who buy at a younger age, and won't change as they get older. Premiums may go up because of inflation and other factors, but not because of applicant's age.
- **Attained-age rated** – The premium is based on the applicant's current age so the premium goes up as the applicant gets older. Premiums are low for younger buyers, but go up as they get older. In addition to change in age, premiums may also go up because of inflation and other factors.

RATE TYPE AVAILABLE BY STATE

State	Tobacco / non-tobacco rates	Gender rates	Attained, issue or community rated	Tobacco rates during open enrollment / guaranteed issue	Enrollment / policy fee
Combined Insurance Company has made the recent decision to discontinue offering a Medicare supplement product in Colorado, Illinois, New Jersey, South Carolina and Texas effective December 1, 2019. These states have been removed from this table.					
AL	Y	Y	A	Y	Y
AZ	Y	Y	I	N	Y
CA	Y	N	A	N	Y
CT	N	N	C	N	Y
FL	Y	Y	I	Y	Y
GA	Y	Y	I	N	Y
IA	Y	Y	A	N	Y
IN	Y	Y	A	Y	Y
KS	Y	Y	A	N	Y
KY	Y	Y	A	N	Y
LA	Y	Y	A	N	Y
MO	Y	Y	I	N	Y
MS	Y	Y	A	N	Y
MT	Y	N	A	Y	Y
NC	Y	Y	A	N	Y
OH	Y	Y	A	N	Y
OK	Y	Y	A	N	Y
PA	Y	Y	A	N	Y
SD	Y	Y	A	Y	Y
TN	Y	Y	A	N	Y
WV	Y	Y	A	Y	N

APPLICATION FEE

There will be a one-time application fee of \$25.00 (\$6.00 in Mississippi, no application fee in West Virginia) that will be collected with each applicant's initial payment. For a husband and wife written on the same application, \$50 in fees must be collected. This will not affect the renewal premiums.

HOUSEHOLD DISCOUNT (NOT APPLICABLE IN ALL STATES)

If question 1 in the Household Discount Section on the application is answered “Yes,” the individual is eligible for the discount. Specific language may vary by state:

A household discount of 6% is available to:	State Availability
<ul style="list-style-type: none">Individuals who, for the past year, have resided with at least one, but no more than three, other adults who are age 50 or older; orIndividuals who live with another adult who is the legal spouse, including validly recognized civil union and/or domestic partners.	CA, KS, SD, WV
<ul style="list-style-type: none">Individuals who, for the past year, have resided with at least one, but no more than three, other adults who are age 18 or older; orIndividuals who live with another adult who is the legal spouse, including validly recognized civil union and/or domestic partners.	KY, MT

The household discount is not available to individuals that have resided with 4 or more Medicare eligible adults for the past year.

COMPLETING THE PREMIUM ON THE APPLICATION

- Premiums are calculated based on the **applicant’s age on the requested effective date**, not at the time of application.

Initial Premium

- Enter the initial Premium Collected in the box located on the application.
- Mark the appropriate mode for the initial payment.

On-going Premium

- Determine how the client wants to be billed going forward (renewal) and select the appropriate mode in the Premium Payment Option section on the application.
- Indicate, based on the mode selected, the On-going premium.
- Monthly direct billing is not allowed.

NOTE: If utilizing Electronic Funds Transfer (“EFT”) as a method of payment, please complete Section 6 of the application. If paying the initial premium by EFT, the completed authorization form must be complete and submitted with the application. The policy will NOT be issued without this authorization.

COLLECTION OF PREMIUM

If not utilizing EFT as a method of payment, at least one month’s premium must be submitted with the application. If a mode other than monthly is selected, then the full modal premium must be submitted with the application. **If monthly mode is selected, the initial premium will draft upon policy issuance.**

- Credit cards and money orders are not accepted.

Combined Insurance Company of America does not accept post-dated checks or payments from Third Parties, including any Foundations as premium for Medicare Supplement, and does not accept premium payments via money order. Immediate family and domestic partners are acceptable payors.

NOTE: Do not mail a copy of the receipt with the application.

NOTICES AND INITIAL PREMIUM RECEIPT

Complete this page as requested. Leave this page of the application package with the applicant.

BUSINESS CHECKS

If premium is paid by a business account, please note this on either the Method of Payment Form or the

Additional Comments Section. Please Note that Business Checks are **only** acceptable if they are submitted for the business owner, or the owner's spouse.

SHORTAGES

Combined Insurance Company of America will communicate with the producer by telephone, e-mail or FAX in the event of a premium shortage in excess of \$5.00 per modal premium. The application will be held in a pending status until the balance of premium is received. Producers may communicate with us by calling 1-855-278-9329 or by FAX at 1-866-545-8076.

REFUNDS

Combined Insurance Company of America will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

OUR GENERAL ADMINISTRATIVE RULE – 12 MONTH RATE

Our current administrative practice is not to adjust rates for 12 months from the effective date of coverage unless limited by regulatory requirement. Florida prohibits this practice.

APPLICATION

NOTE: *Applications that have been modified or converted to fillable forms or other electronic formats will not be accepted unless prior approval was obtained by Combined Insurance Company of America. Attempting to submit unapproved fillable forms or other electronic formats will not speed up the submission of an application.*

Properly completed applications should be finalized within 5-7 days of receipt at Combined Insurance Company of America's administrative office. The ideal turnaround time provided to the producer is 11-14 days, including mail time.

APPLICATION SECTIONS

The application must be completed in its entirety. The Medicare Supplement application consists of eight sections that must be completed. Review your applications for the information in the sections listed below before submitting. Any corrections need to be crossed through and initialed/dated by the applicant. White out on the application is not allowed. Additionally, any incomplete or missed questions may require that you obtain the applicant's initials/date and resubmit. Any corrections that are only initialed by the agent are not acceptable. If you need to submit additional information, or if you need to send in corrected pages, only submit the page(s) required, initialed/dated by the applicant, if needed. Please do NOT send the entire application, if you only need to send a few pages.

PLAN & PREMIUM PAYMENT INFORMATION SECTION

- Entire Section must be completed.
- This section should indicate the Plan or policy form selected, effective date, the policy delivery option (to the agent or to the insured), initial premium paid, the ongoing premium amount, and the premium payment mode selected. Please complete the premium calculation for the proper payment mode selected.

Note: The effective date cannot be on the 29th, 30th, or 31st of the month.

APPLICANT INFORMATION

- Please complete the client's physical (residential) address in full. If any correspondence such as premium notices are to be mailed to an address other than the applicant's physical (residential) address, please complete the Mailing Address (if different from physical address) section in full.
- Make sure the Home Phone No. and Best Time to Contact sections are completed.
- Please complete the applicant's name as listed on the Medicare Card or application for Medicare.
- Current Age is the exact age as of the application date; however, premium is calculated as of the effective date.
- Male/Female, State of Birth, and the Social Security Card number sections are completed.
- Medicare Card number, also referred to as the Health Insurance Claim ("HIC") number, is required for electronic claims payment.
- Please provide the applicant's e-mail address, if available.
- Height/Weight – This is required on underwritten cases.
- Answer the tobacco question – *tobacco use includes use of electronic cigarettes and vaping.* (Note that tobacco rates may not apply during open enrollment or guaranteed issue situations. See the Rate Type Available by State chart on page 15 for specific information.)
- Verify the applicant answered "Yes" to receiving the Guide to Health Insurance and Outline of Coverage and the Notice of Information Practices. It is required to leave these two documents with the client at the time the application is completed.
- Please indicate if the applicant turned 65 in the last six months, if he or she enrolled in Medicare Part B in the last six months, and his or her Medicare Parts A and B effective dates.
- Ensure the question regarding End Stage Renal Disease or Kidney Disease requiring dialysis is answered.

INSURANCE POLICIES

- If the applicant is applying during a guaranteed issue period, be sure to include proof of eligibility.
- If the applicant is replacing another Medicare Supplement policy/certificate, complete question #2 and include the replacement notice.
- If the applicant is leaving a Medicare Advantage Plan, complete question #3 and include the replacement notice and copy of applicant's notice of disenrollment from Medicare Advantage program.
- If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union, employer plan, or other non-Medicare Supplement coverage, complete question #4.
- Verify if the applicant is covered through his/her state Medicaid program. If Medicaid is paying for benefits beyond the applicant's Part B premium or the Medicare Supplement premium for this policy, then the applicant is not eligible for coverage.
- List any additional health insurance policies/certificates you have sold to the applicant.

HEALTH QUESTIONS

- If the applicant is applying during an open enrollment or a guaranteed issue period, do not answer the health questions.
- If applicant is not considered to be in open enrollment or a guaranteed issue situation, or plan selected is not available for GI, all health questions must be answered.

NOTE: In order to be considered eligible for coverage, all health questions must be answered "No."

For instructions on how to answer a particular health question, see the Health Questions section of this guide for clarification.

Medical Condition Information

- Ensure this section is completed for any medical advice, referrals for diagnostic tests, and surgery or treatment for any other condition not listed in Section 4 of the application.

MEDICATION INFORMATION

- If the applicant is applying during an open enrollment or a guaranteed issue period, do not answer the medication information section.
- If applicant is not considered to be in open enrollment or a guaranteed issue situation, or plan selected is not available for GI, all medication information must be listed as indicated.

METHOD OF PAYMENT

- To establish monthly premium payments by EFT (“Electronic Funds Transfer”), complete entirely and submit. Please remember to remind the applicant that the first premium will be withdrawn from the account immediately when the policy is issued.
- Premium for this policy is due on the day of the month that coincides with its effective date. For this reason, we encourage policyholders who request automatic bank draft to choose the draft day to be the same as the effective date.
- Please review the Grace Period definition with your applicants. The policy has a 31-day Grace Period following the paid to date, *not the automatic bank draft date*. If the premium is not paid within that Grace Period, the coverage will lapse. If coverage lapses, the policy is no longer in effect and claims incurred after the last paid to date will be denied. In order to be reinstated, medical underwriting may be required.

AUTHORIZATION AND ACKNOWLEDGEMENT

- Signatures and dates: required by both applicant(s) and producer. The producer must be appointed in the state where the application is signed.

NOTE: Applicant’s signature must match name of applicant on the application. In rare cases where applicant cannot sign his or her name, a mark (“X”) is acceptable if accompanied by a witness signature. For their own protection, the producer does not qualify as a witness.

- If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative. The legal representative should sign their own name as themselves, not as the applicant. Please remember that Power of Attorney will only be accepted on Open Enrollment or Guaranteed Issue applications. A copy of the Power of Attorney document is required prior to issue – please refer to page 12 for more details on the POA Document.

COMPLETED BY PRODUCER

The producer(s) must certify that they have:

- Provided the applicant with a copy of the replacement notice, if applicable.
- Accurately recorded in the application the information supplied by the applicant, and have interviewed the proposed applicant.

NOTE: Applications will only be accepted with an answer of "No" if the producer has submitted the sales process for review and received written prior approval.

- Signatures and dates: required by producer(s).
- The producer must be appointed in the state where the application is signed.

NOTE: If an application is taken on a Kansas resident, the producer must be appointed in Kansas and in the state where the application is signed.

UNDERWRITING & HEALTH QUESTIONS

Unless an application is completed during open enrollment or a guaranteed period, or plan selected is not available for GI, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare Supplement coverage if any of the health questions are answered "Yes", including "Not Sure" in California. For a list of uninsurable conditions and the related medications associated with these conditions, please refer to the next sections in this guide.

HEIGHT AND WEIGHT CHART ELIGIBILITY

The first underwriting question that needs to be determined is whether the applicant is eligible for coverage based on the applicant's build. To determine this, locate the applicant's height, then weight in the chart on the following page. If the weight is in the Decline column, the applicant is not eligible for coverage at this time.

HEIGHT AND WEIGHT CHART

Height	Decline Weight	Standard Weight	Decline Weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10"	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

MEDICATIONS

The Medications Guide beginning on the following page is a partial list of medications associated with Uninsurable Health Conditions. This list is not all-inclusive. An application should not be submitted if a client is taking any of the medications listed for a listed condition / impairment. Example: The applicant takes Aducril for Cancer. This is uninsurable; do not submit the application.

STABILITY PERIOD FOR DIABETES AND HYPERTENSION

If your applicant has recently been diagnosed with Diabetes and Hypertension there is a 6 month stability period required before you can submit an application. This period of time will allow Underwriting to assess whether or not the treatment plan outlined by the physician is doing its job. If during the 6 months an additional medication was added or there was a dosage increase in an existing medication, the applicant must wait another 6 months before being considered for coverage.

NOTE: Depending on the medical condition and response to treatment it may be determined by underwriting that the stability period may need to be longer than 6 months.

CHANGE IN MEDICATION

If your applicant has had a decrease in the dosage of a medication or has had one discontinued due to the condition being controlled at any time, you can submit the application for underwriting consideration.

MEDICATION INFORMATION

All information should be provided:

- Name of medication
- Original date of prescription
- Dosage & frequency
- Condition treated

PARTIAL LIST OF UNINSURABLE MEDICATIONS

MEDICATION	CONDITION / IMPAIRMENT	MEDICATION	CONDITION / IMPAIRMENT
Abacavir	HIV	Becaplermin	Diabetic Ulcers
Abarelix	Cancer	Benzotropine	Tremor, Parkinson's Disease
Abciximab	Antiplatelet	Bepriidil	Angina, Chest Pain
Abilify	Schizophrenia	Betamethasone	Oral / Injectable Steroid
Acridine	Forgetfulness, Disorientation	Betapace	Arrhythmias
Activase	Heart Attack, Stroke, Pulmonary Embolism	Betaseron	Multiple Sclerosis
Adrucil	Cancer	Bevacizumab	Cancer
Aggrastat	Antiplatelet	Bicalutamide	Cancer
Aggrenox	Antiplatelet	Bretylum	Arrhythmia
Agrylin	Essential Thrombocythemia	Bretylol	Arrhythmia
Akineton	Parkinson's Disease	Bromocriptine	Parkinson's Disease
Altretamine	Cancer	Bromocriptine Mesylate	Parkinson's Disease, Pituitary Tumor
Amantadine	Parkinson's Disease	Campral	Alcohol Abuse
Amplex	Alzheimer's Disease	Capecitabine	Cancer
Anagrelide	Abnormal Blood Platelet Count	Carbex	Parkinson's Disease
Anakinra	Rheumatoid Arthritis	Carbidopa	Parkinson's Disease
Ancrod	Anticoagulant Therapy basis	Cedalanid-D	Strengthen The Heart, Arrhythmia
Apokyn	Parkinson's Disease	Celestone	Oral / Injectable Steroid
Apomorphine	Parkinson's Disease	CellCept	Immunosuppressant, Anti-rejection due to organ transplant
Ardeparin	Deep Vein Thrombosis	Ceredase	Gaucher's Disease
Aricept	Chronic Organic Brain Disorders, Alzheimer's Disease	Cerezyme	Gaucher's Disease
Arimidex	Breast Cancer, Cancer	Chlorpromazine	Psychotic Disorders
Aripiprazole	Schizophrenia	Chlorprothixene	Psychosis
Arixtra	Deep Venous Thrombosis	Cilostazol	Antiplatelet
Aromasin	Cancer	Cinacalcet	Hyperparathyroidism
Artane	Parkinson's Disease	Cladribine	Cancer
Arvin	Anticoagulant Therapy	Clopidogrel	Antiplatelet
Asparaginase	Leukemia	Clozapine	Psychotic Disorders
Atamet	Parkinson's Disease	Clozaril	Psychotic Disorders
Atrovent	Emphysema, COPD	Cogentin	Psychotic Disorders
Auranofin	Rheumatoid Arthritis	Cognex	Chronic Organic Brain Disorders
Aurothioglucose	Rheumatoid Arthritis	Colchicine	Scleroderma
Aurothiomalate	Rheumatoid Arthritis	Collagen-Alginate Topical	Diabetic Ulcers
Avastin	Cancer	Combivir	HIV
Avonex	Multiple Sclerosis	Compazine	Psychosis
AZT	HIV	Comvax	Parkinson's Disease

MEDICATION	CONDITION / IMPAIRMENT	MEDICATION	CONDITION / IMPAIRMENT
Copaxone	Multiple Sclerosis	Eliquis	Cardiovascular, anti-coagulant
Cordarone	Arrhythmia	Emcyt	Prostate Cancer, Cancer
Cortisone	Oral / Injectable Steroid	Enbrel	Rheumatoid Arthritis
Cortone Acetate	Oral / Injectable Steroid	Enoxaparin	Prevention Of Deep Vein Thrombosis
Cotazym	Pancreatic Insufficiency	Entacapone	Parkinson's Disease
Coumadin	Arrhythmia, Heart Valve Disease, Stroke, CAD, Embolism	Epogen	Severe Anemia
Crystodigin	Arrhythmia, Strengthen The Heart, CHF	Eptifibatide	Antiplatelet
Cuprimine	Rheumatoid Arthritis, Wilson's Disease, Kidney Stones	Ergoloid	Dementia, Confusion, Disorientation, Forgetfulness, Memory Loss
Cyclandelate	TIA, Memory Loss, Dementia	Erythryl	Angina, Chest Pain
Cyclophosphamide	Chronic Active Hepatitis, Regional Enteritis, Ulcerative Colitis, Cancer, Kidney Failure	Erythropoietin	Severe Anemia
Cyclosporine	Lupus, Scleroderma, Cancer, Organ Transplant	Eskalith	Bipolar Disorder
Cytosan	Chronic Active Hepatitis, Regional Enteritis, Ulcerative Colitis, Cancer, Kidney Failure, Lupus, Scleroderma	Etanercept	Rheumatoid Arthritis, Pain Reliever
Dalalone	Injectable Steroid	Ethmozine	Arrhythmia
Dalteparin	Anticoagulant Therapy	Ethopropazine	Parkinson's Disease
Danaparoid	Deep Venous Thrombosis	Exelon	Alzheimer's Disease
Decadron	Oral / Injectable Steroid	Fareston	Breast Cancer, Cancer
Deferoxamine	Hemochromatosis	Faslodex	Cancer
Depen	Rheumatoid Arthritis, Kidney Stones, Wilson's Disease	Femara	Breast Cancer, Cancer
Depo-Medrol	Injectable Steroid	Fibracol	Diabetic Ulcers
Deponit NTG	High Blood Pressure, Angina, Chest Pain	Flecainide	Arrhythmia
Deprynel	Parkinson's Disease	Florinef	Addison's Disease
Desferal	Hemochromatosis	Flosequinan	Congestive Heart Failure
Destinex	Parkinson's Disease	Fludrocortisone	Addison's Disease, Complications of Diabetes
Dexamethasone	Oral / Injectable Steroid	Fluphenazine	Psychotic Disorders
Dexasone	Oral / Injectable Steroid	Folex (Methotrexate)	All Conditions
Digoxin	Arrhythmia, Congestive Heart Failure, or other Heart Condition	Fragmin	Anticoagulant Therapy
Dipyridamole	Antiplatelet, Stroke	Frova	Migraine Headaches
Donepezil	Chronic Organic Brain Disorders	Furosemide (80mg or more/day)	All Conditions
D-Penicillamine	Scleroderma, Lupus	Glatiramer	Multiple Sclerosis
Eldepryl	Psychotic Disorders	Gold	Arthritis

MEDICATION	CONDITION / IMPAIRMENT	MEDICATION	CONDITION / IMPAIRMENT
Gold Sodium Thiomalate	Rheumatoid Arthritis	Lantus	Insulin Dependent Diabetes Mellitus
Haldol	Psychotic Disorders	Lasix (80mg or more/day)	All Instances
Haloperidol	Psychotic Disorders	L-Dopa	Parkinson's Disease
Heparin	Blood Clotting Disorder	Lente Insulin	Insulin Dependent Diabetes Mellitus
Hexadrol	Oral / Injectable Steroid	Letrozole	Breast Cancer, Cancer
Humalog	Insulin Dependent Diabetes Mellitus	Leucovorin	Cancer
Humira	Rheumatoid Arthritis	Levodopa	Parkinson's Disease
Humulin	Insulin Dependent Diabetes Mellitus	Lioresal	Multiple Sclerosis
Hydeltra	Injectable Steroid	Liquid Pred	Oral Steroid
Hydeltrasol	Injectable Steroid	Lithane	Bipolar Disorder
Hydergine	Chronic Organic Brain Disorders	Lithium	Bipolar Disorder
Hydrea	Cancer, Sickle Cell Anemia	Lithium Carbonate	Bipolar Disorder
Hydrocortisone	Oral / Injectable Steroid	Lithobid	Bipolar Disorder
Hydrocortone	Injectable Steroid	Lithonate	Bipolar Disorder
Iletin II NPH Pork	Insulin Dependent Diabetes Mellitus	Lithotabs	Bipolar Disorder
Iletin II Regular Pork	Insulin Dependent Diabetes Mellitus	Lopurin	Immunosuppressant
Iletin Lente	Insulin Dependent Diabetes Mellitus	Loxapine	Psychotic Disorders
Iletin NPH	Insulin Dependent Diabetes Mellitus	Loxitane	Psychotic Disorders
Iletin Regular	Insulin Dependent Diabetes Mellitus	Lupron	Prostate Cancer, Cancer
Ilopan Choline	Insulin Dependent Diabetes Mellitus	Manoplax	Congestive Heart Failure
Imferon	Anemia	Mellaril	Psychotic Disorders
Imiglucerase Injection	Gaucher's Disease	Mesoridazine	Psychotic Disorders
Imuran	Chronic Active Hepatitis, Regional Enteritis, Ulcerative Colitis	Mestinon	Myasthenia Gravis
INH	Tuberculosis (TB)	Methotrexate (15mg or more/week)	All Conditions
Insulin	Insulin Dependent Diabetes Mellitus	Methylprednisolone	Oral / Injectable Steroid
Insulin Lispro	Insulin Dependent Diabetes Mellitus	Mirapex	Parkinson's Disease
Integrilin	Anti-platelet	Mithramycin	Paget's Disease
Interferon	Cancer, Hepatitis, AIDS	Moban	Psychotic Disorders
Isoniazid	TB (Tuberculosis)	Modafinil	Narcolepsy
Isordil	Angina, Chest Pain, CHF	Molindone	Psychotic Disorders
Isosorbide Dinitrate	Angina, Congestive Heart Failure	Myolin	Parkinson's Disease
Kemadrin	Parkinson's Disease	Myotrophin	ALS, Lou Gehrig's Disease
Kenalog	Injectable Steroid	Namenda	Alzheimer's Disease
Kineret	Rheumatoid Arthritis	Navane	Psychotic Disorders
Lanoxicaps	Strengthen The Heart, Arrhythmia, CHF, or for any Heart Condition	Neosar	Immunosuppressant, Cancer

MEDICATION	CONDITION / IMPAIRMENT	MEDICATION	CONDITION / IMPAIRMENT
Neostigmine	Myasthenia Gravis	Permax	Parkinson's Disease
Nesiritide	Congestive Heart Failure	Permitil	Psychotic Disorders
Nilandron	Prostate Cancer	Perphenazine	Psychotic Disorders
Niloric	Dementia, Confusion, Disorientation, Forgetfulness, Memory Loss	Phenothiazine	Psychotic Disorders
Nilutamide	Prostate Cancer	Pimozide	Schizophrenia
Nipride	Angina, Chest Pain	Piperacetazine	Psychotic Disorders
Nitro Td Patch-A	Angina, Chest Pain	Plavix	Anti-platelet, Angina, Stroke Prevention
Nitrobid	Angina, Chest Pain	Pletal	Antiplatelet
Nitro-Bid	Angina, Chest Pain	Pramipexole	Parkinson's Disease
Nitrodisc	Angina, Chest Pain	Pramlintide	Insulin-Dependent Diabetes Mellitus
Nitro-Dur	Angina, Chest Pain	Prednisolone	Oral / Injectable Steroid
Nitrodur/	Angina, Chest Pain	Prednisone (more than 10mg/day)	Oral Steroid
Nitrogard	Angina, Chest Pain	Procainamide	Arrhythmia
Nitroglycerin	Angina, Chest Pain	Procan	Arrhythmia
Nitroglycerine	Angina, Chest Pain	Prochlorperazine	Psychotic Disorders
Nitroglyn	Angina, Chest Pain	Procrit	Kidney Failure
Nitroglyn E-R	Angina, Chest Pain	Procyclidine	Parkinson's Disease
Nitrol	Angina, Chest Pain	Proketazine	Psychotic Disorders
Nitrolingual	Angina, Chest Pain	Prolixin	Psychotic Disorders
Nitropress	Angina, Chest Pain	Promazine	Psychosis
Nitrospan	Angina, Chest Pain	Pronestyl	Arrhythmia
Nitrostat	Angina, Chest Pain	Propacet 100	Pain Reliever
Nolvadex	Cancer	Prostigmin	Myasthenia Gravis
Novolin 70/30	Insulin Dependent Diabetes Mellitus	Pyridostigmine	Myasthenia Gravis
NTG	Angina, Chest Pain	Quetiapine Fumarate	Psychotic Disorders
Olanzapine	Psychotic Disorders	Quinidex	Arrhythmia
Orap	Tourette's Syndrome	Quinidine	Arrhythmia
Pacerone	Ventricular Arrhythmia	Quinora	Arrhythmia
Pancrease	Pancreatic Insufficiency	Regranex	Diabetic Ulcers
Pancreatin	Pancreatic Insufficiency	Remicade	Rheumatoid Arthritis
Pancrelipase	Pancreatic Insufficiency	Reminyl	Alzheimer's Disease
Parlodel	Parkinson's Disease	Repoise	Psychotic Disorders
Parsidol	Parkinson's Disease	Requip	Parkinson's Disease
Pentaerythritol Tetranitrate	Angina, Chest Pain	Rezulin	Diabetes Mellitus
Pergolide	Parkinson's Disease	Rheopro	Antiplatelet
Pergolide Mesylate	Parkinson's Disease	Rheumatrex	Lupus, Scleroderma, Leukemia, Lymphoma, Rheumatoid Arthritis

MEDICATION	CONDITION / IMPAIRMENT	MEDICATION	CONDITION / IMPAIRMENT
Ridaura	Rheumatoid Arthritis	Taractan	Psychotic Disorders
Riluzole	ALS, Lou Gehrig's Disease	Tasmar	Parkinson's Disease
Risperdal	Psychotic Disorders	Tetracyclic	Psychotic Disorders
Risperidone	Psychotic Disorders	Tetrahydroamino Acridine (THA)	Dementia, Confusion, Disorientation, Forgetfulness, Memory Loss
Rituxan	Non-Hodgkin's Lymphoma	Thioridazine	Psychotic Disorders
Rituximab	Recurrent Non-Hodgkin's Disease	Thiothixene	Psychotic Disorders
Ropinirole	Parkinson's Disease	Thioxanthene	Psychotic Disorders
Sandimmune	Lupus, Scleroderma, Cancer, Organ Transplant	Thorazine	Psychotic Disorders
Selegiline	Parkinson's Disease	Ticlid	Anti-platelet, Stroke, TIA
Serentil	Psychotic Disorders	Ticlopadine	Anti-platelet, Stroke, TIA
Serlect	Schizophrenia	Ticlopidine	Anti-platelet, Stroke, TIA
Seroquel	Psychotic Disorders	Tindal	Psychotic Disorders
Sertindole	Schizophrenia	Tolcapone	Parkinson's Disease
Sinemet	Restless Leg Syndrome, Parkinson's Disease	Transderm-Nitro	High Blood Pressure, Angina, Chest Pain
Solganal	Rheumatoid Arthritis	Trifluoperazine	Psychotic Disorders
Solu-Cortef	Injectable Steroid	Triflupromazine	Psychotic Disorders
Solu-Medrol	Injectable Steroid	Trilafon	Psychotic Disorders
Sparine	Psychosis	Troglitazone	Diabetes Mellitus
Stalevo	Parkinson's Disease	Vascor	Angina, Chest Pain
Stelazine	Psychotic Disorders	Vesprin	Psychotic Disorders
Symbyax	Psychotic Disorders	Viokase	Pancreatic Insufficiency
Symmetrel	Parkinson's Disease	Warfarin	Arrhythmia, Heart Valve Disease, Stroke, CAD, Embolism
Tacrine	Dementia, Confusion, Disorientation, Forgetfulness, Memory Loss	Xarelto	Cardiovascular, anti-coagulant
Tambocor	Arrhythmia	Zoladex	Prostate Cancer, Cancer
Tamoxifen	Cancer	Zyprexa	Psychotic Mental Disorders, Schizophrenia

CANCER QUESTIONS

With respect to the question on the application concerning treatment for internal cancer, malignant melanoma is considered an internal cancer. Applicants with this type of cancer are not eligible for coverage. Other types of skin cancer, such as basal cell, are not considered internal.

DIABETES QUESTIONS

There are 2 questions on the application that deal with Diabetes.

First, “Do you have diabetes that requires insulin?” People with diabetes mellitus that require insulin are not eligible for coverage.

The second question asks, “Do you have diabetes that is treated by medication or by diet?” If this question is answered Yes”, including “Not Sure” in California, the applicant must complete questions A-F. If the answer to any of the questions A-F is Yes”, including “Not Sure” in California, the applicant would not be eligible for coverage. Some additional questions to ask your client to determine if he/she does have a complication include:

- Does he/she have eye/vision problems?
- Does he/she have numbness or tingling in the toes or feet?
- Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with controlled hypertension and diabetes. An applicant is considered to be controlled if their A1C reading is 7 or under and their blood pressure readings are 150/90 or below. In general, to verify stability there should be no other medical complications related to diabetes or high blood pressure and their A1C and blood pressure reading are within the standards provided above. Individual consideration will be given when appropriate.

UNINSURABLE HEALTH CONDITIONS

CONDITION / IMPAIRMENT	CONDITION / IMPAIRMENT
Addison’s Disease	HIV
AIDS (AIDS Related Complex)	Insulin Dependent Diabetes Mellitus
ALS (Lou Gehrig’s Disease)	Kidney Disease requiring dialysis
Alzheimer’s Disease	Chronic Kidney Disease
Chronic Active Hepatitis	Lupus
Cirrhosis	Multiple Sclerosis
COPD and other chronic pulmonary disorders to include:	Myasthenia Gravis
Bronchiectasis	Organ Transplant
Chronic bronchitis	Osteoporosis with fracture
COLD (Chronic Obstructive Lung Disease	Parkinson’s Disease
* Chronic Asthma	Psychotic Disorders
Chronic Interstitial Lung Disease	Schizophrenia
Chronic Pulmonary Fibrosis	Scleroderma
Cystic Fibrosis	Senile Dementia / Other cognitive disorders to include:
Sarcoidosis	Mild cognitive impairment (“MCI”)
Dementia	Delirium
Emphysema	Organic brain disorder
Epilepsy/Seizures – <i>uncontrolled</i>	Spinal Stenosis < 2 years
ESRD - End-Stage Renal Disease (refer to under age requirements)	Stroke

In addition to the above conditions, the following will also lead to a decline:

- Implantable cardiac defibrillator
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, treatment or therapy
- If applicant's height/weight is in the decline column on the chart
- Currently receiving hospice, home health care
- Applicant requiring assistance with any ADLs (Activities of Daily Living)
- Bedridden, confined to wheelchair
- Three or more inpatient hospitalization in the past two years
- Use of supplemental oxygen (except if used for Obstructive Sleep Apnea)
- * Chronic asthma requiring continuous use of three or more medications including inhalers
- Depending on the medical condition, Use of a nebulizer may lead to a decline.

REQUIRED FORMS

APPLICATION

Only current Medicare Supplement applications may be used in applying for coverage. A copy of the completed application will be made by Combined Insurance Company of America and attached to the policy to make it part of the contract.

The agent is responsible for submitting completed applications to Combined Insurance Company of America's administrative office.

AGENT CERTIFICATION

This form must be signed by the agent and the applicant(s) and returned with the application.

MEDICAL RELEASE

Authorization to release confidential medical information is included in the signature page. The form must have a current and clearly written date. It is required with all underwritten applications.

METHOD OF PAYMENT FORM

Complete this required form regarding payment options and submit with all applications.

PREMIUM AND NOTICE OF INFORMATION PRACTICES

Receipt must be completed and provided to applicant as receipt for premium collected. Notice must be provided to applicant.

REPLACEMENT FORM(S)

The replacement form(s) must be signed and submitted with the application when replacing any Medicare Supplement or Medicare Advantage application. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application.

CREDITABLE COVER LETTER

If the applicant is claiming a Guaranteed Issue right, a letter of creditable coverage is needed from the prior insurance carrier (either employer/group coverage) that informs the new insurance carrier that the policyholder has had recent health care insurance coverage which qualifies for Guaranteed Issue.

DISENROLLMENT LETTER

This is a letter from the prior Medicare Advantage carrier providing the type of plan, effective dates, and policyholder's name and stating that the policy holder is no longer covered.

STATE SPECIFIC REQUIREMENTS & FORMS

Forms specifically mandated by states to accompany point of sale material.

CALIFORNIA

Requirements for Under Age 65 – Plans A and F are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65. Not available for individuals with end Stage Renal Disease.

Loss of Medicaid Qualification Rights – Applicants is enrolled in Medicare Part B, and as a result of an increase in income or assets, is no longer eligible for Medi-Cal benefits, or is only eligible for Medi-Cal benefits with a share cost and certify at the time of application that they have not met the share of cost. Open Enrollment beginning with notice of termination and ending six months after the termination date.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan’s benefits are reduced, with Part B coinsurance no longer being covered.

Birthday Rule – California requires a Guaranteed Issue period around the applicant’s birthday – giving the applicant the opportunity to switch policies on a Guaranteed Issue basis annually. The application window lasts for 90 days, beginning 30 days before and ending 60 days after the applicant’s birthday. Eligibility verification is required.

CONNECTICUT

Applications – Applications must be taken face-to-face. eApplication is not available.

Medical Underwriting – There is no medical underwriting of applications in the state of Connecticut.

Requirements for Under Age 65 – Plan A is available.

FLORIDA

Form: Agent Disclosure Form – This form is to be completed by the agent; signed by the agent and applicant and submitted with the application.

Requirements for Under Age 65 – Plans A, F, and G are available. Applications submitted outside of the Open Enrollment period will be subject to the same underwriting criteria used for applicants who are 65 or older and outside of the Open Enrollment period.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan’s benefits are reduced substantially.

GEORGIA

Requirements for Under Age 65 – Plans A and G are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65. Retroactive enrollment allowed when due to a retroactive eligibility decision made by the SSA. Coverage is also available to individuals under age 65 and on Medicare disability due to End Stage Renal Disease (ESRD). Applications written outside this open enrollment period will be declined and premium will be refunded.

INDIANA

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan is primary to Medicare.

Requirements for Under Age 65 – Plans A is available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.

KANSAS

Requirements for Under Age 65 – Plans A, F, and G are available. Open enrollment if applied for within six months of Part B enrollment. If applying outside this open enrollment period, the application is subject to underwriting and must qualify medically.

Loss of Medicaid Qualification Rights – Applicants have a Guaranteed Issue right for loss of health benefits under Medicaid. Applicant has the right to buy any plan sold by any insurer.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage.

KENTUCKY

Form: Medicare Supplement Comparison Statement – Form should be completed when replacing a Medicare Supplement or Medicare Advantage plan and submitted with the application.

Requirements for Under Age 65 – Plans A, F, G, and N are available. No open enrollment. All applications are underwritten. Always use Non-Tobacco rates.

LOUISIANA

Form: Your Rights Regarding the Release and Use of Genetic Information – Refer to the section on page 10 of the application with the applicant.

Requirements for Under Age 65 – Plans A, G and N are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage.

MISSISSIPPI

Requirements for Under Age 65 – Plans A, F and N are available. Open enrollment if applied for within six months of Part B enrollment. If applying outside this open enrollment period, the application is subject to underwriting and must qualify medically. A separate premium band applies to individuals under age 65.

Application Fee – The application fee in Mississippi is \$6.00.

MISSOURI

Requirements for Under Age 65 – Plans A, F, G and N are available. Open enrollment if applied for within six months of Part B enrollment. If applying outside this open enrollment period, the application is subject to underwriting and must qualify medically. A separate premium band applies to individuals under age 65.

Anniversary Rule – Missouri requires a Guaranteed Issue period around the applicant’s policy anniversary date – giving the applicant the opportunity to switch policies on a Guaranteed Issue basis annually for 30 days before or after the existing policy’s anniversary. Eligibility verification is required.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage.

MONTANA

Requirements for Under Age 65 – Plans A, F, G and N are available. Open enrollment if applied for within six months of Part B enrollment. If applying outside this open enrollment period, the application is subject to underwriting and must qualify medically. Open enrollment also applies during the 63-day period following termination of coverage under a group or individual health insurance policy or certificate for a person enrolled, or eligible for enrollment in Medicare Part B.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan is primary to Medicare.

NORTH CAROLINA

Requirements for Under Age 65 – Plans A, F and G are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.

OHIO

Form: Sales Appointment Form – Form must be completed, signed and submitted with the application. In completing this Appointment Form, the form number is the Plan Form number for each plan being applied for and is listed on the Outline of Coverage rate page:

Plan A – 14903; Plan F – 14905; Plan G – 14980; Plan N – 14906.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan is primary to Medicare.

OKLAHOMA

Requirements for Under Age 65 – Plan A is available. There is an open enrollment period for the first 6 months after the effective date of Part B. If applying outside this open enrollment period, the application is subject to underwriting and must qualify medically. A separate premium band applies to individuals under age 65.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan’s benefits are reduced substantially.

PENNSYLVANIA

Requirements for Under Age 65 – Plans A, B, F, G and N are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.

Policy Delivery – Our administrative rule is that all policies are to be mailed directly to the policyholder.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan is primary to Medicare.

SOUTH DAKOTA

Changes to the Application – Any change made on the application must be initialed and dated by the applicant.

Requirements for Under Age 65 – Plans A, F, G and N are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage.

TENNESSEE

Requirements for Under Age 65 – Plans A, F, G, and N are available. Applications are only accepted during Open Enrollment. If the applicant does not apply for a policy during this open enrollment period, you cannot write an application until the “Federal Open Enrollment Period” when the applicant turns age 65.

Loss of Medicaid Qualification Rights – Applicants, age 65 and older, have a Guaranteed Issue right for involuntary loss of Medicaid (TennCare) beginning with the notice of termination and ending 63 days after the termination date. Applicants, under age 65, have a 6 month Open Enrollment period for loss of Medicaid (TennCare) beginning on the date of involuntary loss of coverage. Applicants have the right to buy Plan A or F.

WEST VIRGINIA

Guaranteed Issue Right for Voluntary Termination of Group Health Plan – The applicant has a Guaranteed Issue right for voluntary loss of Group Health Plan Coverage if the employer sponsored plan’s benefits are reduced substantially.

Application Fee – There is no application fee in West Virginia.



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