Application for Medicare Supplement Insurance

Florida

022818

Agent checklist for completing the Medicare Supplement Application

Please return all pages marked **"RETURN TO COMPANY"** and leave the Outline of Coverage booklet and pages marked **"LEAVE WITH APPLICANT"** with the applicant(s).

Speed up the processing by double checking the following:

- ❑ Application's personal information completed
  (DOB, Gender, SSN, Medicare number/dates)
- ❑ All dates completed
  (Effective dates, signature date)
- ❑ Replacement, Investigative Consumer Report Notice/MIB Disclosure Notice, and Agent Certification forms completed
  (Signed & dated and submitted with application)
- ❑ Premium and payment information completed
  (Modal Premium listed, Bank information complete)
- ❑ Prior coverage information completed
  (Carrier, plan, start & end dates)

Important Notice:

EFT Premium Payments will be drafted **upon issuance**

PLEASE NOTE — you are also required to provide the applicant(s) with the following items:

- ❑ Guide to Health Insurance for People with Medicare
- ❑ Outline of Coverage

Mailing Address
Combined Insurance Company of America
PO Box 14207
Clearwater, FL 33766-4207

Overnight/Express Address
Combined Insurance Company of America
2650 McCormick Drive, Suite 200T
Clearwater, FL 33759

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

Application For: Medicare Supplement Coverage

Combined Insurance Company of America

Administrative Office
PO Box 14207 • Clearwater, FL 33766-4207
Toll-free 855-278-9329 • www.combinedinsurance.com

Writing Agent Name	Writing Agent License Identification #

SECTION 1. PLAN & PREMIUM PAYMENT INFORMATION - TO BE COMPLETED BY PRODUCER

NOTE: If more than 1 applicant, complete Applicant B sections.

Applicant A	Applicant B
Medicare Supplement Plan Applied for: ☐ Plan A ☐ Plan F ☐ Plan G	Medicare Supplement Plan Applied for: ☐ Plan A ☐ Plan F ☐ Plan G
Requested Effective Date _____/_____/_____ mo / day / yr	Requested Effective Date _____/_____/_____ mo / day / yr
Mail Policy To: ☐ Insured ☐ Agent	Mail Policy To: ☐ Insured ☐ Agent
Initial Premium (include one-time policy fee) $_____+ $ 25.00 _____= $_____	Initial Premium (include one-time policy fee) $_____+ $ 25.00 _____= $_____
Ongoing Premium $_____	Ongoing Premium $_____

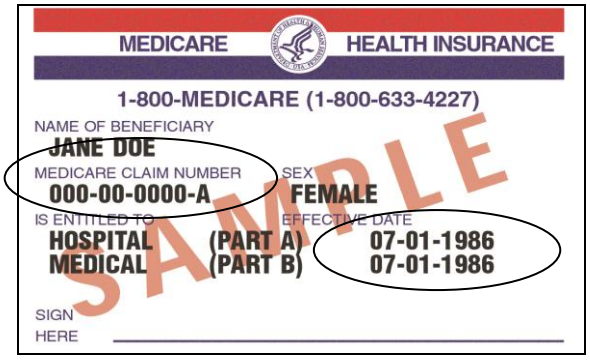
Select Premium Payment Option (Initial Premium includes one-time policy fee.):
☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Electronic Funds Transfer/Monthly

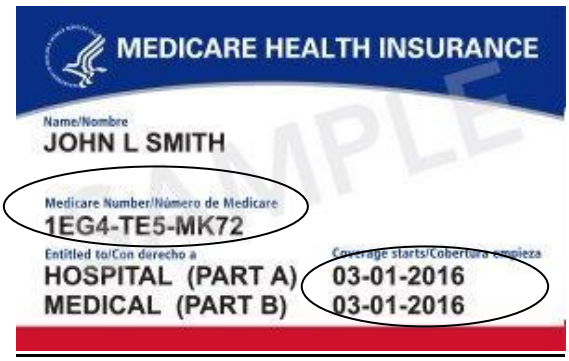
SECTION 2. APPLICANT INFORMATION – PLEASE ANSWER ALL QUESTIONS COMPLETELY

Applicant A	Applicant B
Name (First/Middle/Last) should match Medicare health ins. card.	Name (First/Middle/Last) should match Medicare health ins. card.
Physical Address	Physical Address
City	City
State ZIP _____+_____	State ZIP _____+_____
Mailing Address (if different from physical address)	Mailing Address (if different from physical address)
City	City
State ZIP _____+_____	State ZIP _____+_____
Home Phone No. (_____) _____-_____ (area code)	Home Phone No. (_____) _____-_____ (area code)
Best Time to Contact:	Best Time to Contact:

Application For: Medicare Supplement Coverage

SECTION 2. APPLICANT INFORMATION, CONTINUED – PLEASE ANSWER ALL QUESTIONS COMPLETELY	
Current Age_____ Date of Birth_____/_____/_____ mo / day / yr	Current Age_____ Date of Birth_____/_____/_____ mo / day / yr
☐ Male ☐ Female State of Birth _____	☐ Male ☐ Female State of Birth _____
Social Security No. _____-_____-_____	Social Security No. _____-_____-_____
Please reference your Medicare Card to complete this section.	





Applicant A	Applicant B	
Medicare Health Insurance Card Claim Number (if known)	Medicare Health Insurance Card Claim Number (if known)	
Medicare Number (if known)	Medicare Number (if known)	
E-mail Address	E-mail Address	
In the last 12 months, have you smoked cigarettes, e-cigarettes, cigars, pipe or used nicotine products? ☐ Yes ☐ No	In the last 12 months, have you smoked cigarettes, e-cigarettes, cigars, pipe or used nicotine products? ☐ Yes ☐ No	
Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage** and the **Notice of Information Practices?**.....	**Applicant A** ☐ Yes ☐ No	**Applicant B** ☐ Yes ☐ No
To the Best of your Knowledge: 1. Did you turn age 65 in the last 6 months?..... 2. Did you enroll in Medicare Part B in the last 6 months?... Please complete the following: Medicare Part A Effective Date:…… Medicare Part B Effective Date:……	 ☐ Yes ☐ No ☐ Yes ☐ No ____/____/_____ ____/____/_____	 ☐ Yes ☐ No ☐ Yes ☐ No ____/____/_____ ____/____/_____
Are you applying for coverage because you have been diagnosed or treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis?.....	☐ Yes ☐ No	☐ Yes ☐ No

Application For: Medicare Supplement Coverage

SECTION 3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.

To the Best of Your Knowledge:	**Applicant A**	**Applicant B**
1. Are you applying during a guaranteed issue period? ..... **(NOTE: If the answer above is "YES," please attach proof of eligibility.)**	☐ Yes ☐ No	☐ Yes ☐ No
2. Do you have another Medicare Supplement or Medicare Select insurance policy or certificate in force? ..... (a) If "YES," with what company, and what plan do you have?	☐ Yes ☐ No	☐ Yes ☐ No
Applicant A	**Applicant B**	
Name of Company	Name of Company	
Plan	Plan	
Effective Date ____/____/_____	Effective Date ____/____/_____	
	Applicant A	**Applicant B**
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date.....	____/____/_____	____/____/_____
(d) If "YES," have you received a copy of the replacement notice?	☐ Yes ☐ No	☐ Yes ☐ No
(e) NOT INCLUDING Medicare Supplement, have you had before or do you now have any other Medicare plan coverage as referenced below? ..... If you answer "NO" skip to question #4 below. If you answer "YES," please complete questions 3 (a-g) below.	☐ Yes ☐ No	☐ Yes ☐ No
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave "END" blank……	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(b) If "YES," have you received a copy of the replacement notice?.....	☐ Yes ☐ No	☐ Yes ☐ No
(c) Reason for termination/disenrollment?	_____ Applicant A	_____ Applicant B
(d) Planned date of termination/disenrollment?	____/____/_____ Applicant A	____/____/_____ Applicant B

Application For: Medicare Supplement Coverage

SECTION 3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have. (CONTINUED)

	Applicant A	Applicant B
(e) Was this your first time in this type of Medicare supplement plan?	☐ Yes ☐ No	☐ Yes ☐ No
(f) Did you drop a Medicare Supplement or Medicare select policy/certificate to enroll in this Medicare plan? .... If "YES,"	☐ Yes ☐ No	☐ Yes ☐ No
(g) Is your former Medicare Supplement plan or Medicare select policy/certificate still available?.....	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you had coverage under any other health insurance within the past 63 days? ..... (For example, an employer, union, or individual non-Medicare Supplement plan) (a) If "YES," with what company and what kind of policy/certificate? (List below.)	☐ Yes ☐ No	☐ Yes ☐ No

Applicant A		Applicant B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

	Applicant A	Applicant B
(b) What are your dates of coverage under the other policy/ certificate? If you are still covered under this plan, leave "END" blank. (c) Reason for termination/disenrollment? _____/_____ **Applicant A** **Applicant B**	Start ____/____/_____ End ____/____/_____	Start ____/____/_____ End ____/____/_____
(d) Planned date of termination/disenrollment?	____/____/_____	____/____/_____
5. Are you covered for medical assistance through the state Medicaid program?..... (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES",	☐ Yes ☐ No	☐ Yes ☐ No
(a) Will Medicaid pay your premiums for this Medicare Supplement policy?.....	☐ Yes ☐ No	☐ Yes ☐ No
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?.....	☐ Yes ☐ No	☐ Yes ☐ No
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant. (a) List policies/certificates sold which are still in force.		

Applicant A	Applicant B
Name of Company	Name of Company
Description of Benefits	Description of Benefits
Effective Date of Coverage / /	Effective Date of Coverage / /

(b) List policies/certificates sold in the past five (5) years which are no longer in force.

Applicant A	Applicant B

Application For: Medicare Supplement Coverage

Are you applying during Open Enrollment or a Guaranteed Issue period? If yes, SKIP SECTIONS 4 and 5; GO TO SECTION 6.

- **SECTION 4. HEALTH QUESTIONS If either Applicant A or Applicant B answer "YES" to any of the following questions 1-13, that person is not eligible for Medicare Supplement Coverage.**

Applicant A	Applicant B
Height: ___ Ft _____ In Weight: _____ Lbs	Height: ___ Ft _____ In Weight: _____ Lbs

	Applicant A	Applicant B
1. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair?.....	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed or treated by a licensed health care practitioner or physician for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed or treated by a licensed health care practitioner or physician for Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?.....	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been diagnosed or treated by a licensed health care practitioner or physician for Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?.....	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?.....	☐ Yes ☐ No	☐ Yes ☐ No
6. Within the past two years have you been diagnosed, treated or advised by a licensed health care practitioner or physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?.....	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past two years have you been diagnosed, treated or advised by a licensed health care practitioner or physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?.....	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past two years have you been treated by a licensed health care practitioner or physician for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you been advised by a licensed health care practitioner or physician that surgery may be required within the next 12 months for cataracts?.....	☐ Yes ☐ No	☐ Yes ☐ No
10. Have you been advised by a licensed health care practitioner or physician to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you been hospital confined three or more times in the last two years?	☐ Yes ☐ No	☐ Yes ☐ No
12. Have you had an organ transplant or been advised by a licensed health care practitioner or physician to have an organ transplant?.....	☐ Yes ☐ No	☐ Yes ☐ No
13. Do you have diabetes that requires insulin?.....	☐ Yes ☐ No	☐ Yes ☐ No
14. Do you have diabetes that is treated by medication or by diet?	☐ Yes ☐ No	☐ Yes ☐ No
If yes, as a result of your diabetes do you have;		
A. Numbness in your hands, feet or legs?	☐ Yes ☐ No	☐ Yes ☐ No
B. Eye disorder?	☐ Yes ☐ No	☐ Yes ☐ No
C. Kidney problems?	☐ Yes ☐ No	☐ Yes ☐ No
D. Circulatory or peripheral vascular disease?	☐ Yes ☐ No	☐ Yes ☐ No
E. Skin ulcers?	☐ Yes ☐ No	☐ Yes ☐ No
F. Amputation(s)?	☐ Yes ☐ No	☐ Yes ☐ No
(If applicant answers "YES" to any of questions A-F then applicant is not eligible for coverage.)		

Application For: Medicare Supplement Coverage

SECTION 4. HEALTH QUESTIONS. (CONTINUED)		
To the best of your knowledge, within the past two (2) years have you had any medical advice by a licensed health care practitioner or physician, including referrals to other physicians for diagnostic test(s) and surgery or treatment from a member of the medical profession, for any other condition not listed in section 4?		
Applicant A ☐ Yes ☐ No (please attach a separate sheet if needed)		**Applicant B** ☐ Yes ☐ No (please attach a separate sheet if needed)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)
	Specific Condition	
	Type of Treatment	
Begin: ____/____/______ End: ____/____/______ (leave blank if current)	Dates of Diagnosis	Begin: ____/____/______ End: ____/____/______ (leave blank if current)

Application For: Medicare Supplement Coverage

SECTION 5. MEDICATION INFORMATION		
1. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.		
Applicant A ☐ Yes ☐ No (please attach a separate sheet if needed)		**Applicant B** ☐ Yes ☐ No (please attach a separate sheet if needed)
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (as shown on label)	
___/___/_____	Date **Originally** Prescribed	___/___/_____
	Frequency and Dosage	
	Diagnosis/Condition	

Application For: Medicare Supplement Coverage

SECTION 6. METHOD OF PAYMENT – PLEASE COMPLETE ALL QUESTIONS

IMPORTANT: When choosing to pay initial premium by Electronic Funds Transfer/Monthly,

THE FIRST PREMIUM WILL BE WITHDRAWN FROM YOUR ACCOUNT IMMEDIATELY WHEN YOUR POLICY IS ISSUED.

The first withdrawal date may be different from the monthly date selected for renewal premiums. Subsequent premiums will be withdrawn approximately thirty (30) days from the effective date of coverage or on the date specified on this application.

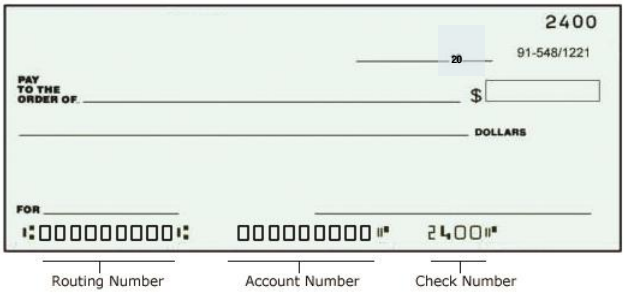
I authorize Combined Insurance Company of America to withdraw funds from my account for my initial and/or monthly renewal premiums. I understand that the Initial Premium includes a one-time policy fee. Premium shortages may result from a variety of causes. I authorize you, my financial institution, to pay from my account to "Combined Insurance Company of America" any preauthorized electronic fund transfers. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

I would like my electronic funds transfer to come from my (check one below) on the _____ day (must be between the 1st and 28th) of the month:

Checking ☐
Please attach a voided check

Savings ☐
Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.

- Payments cannot be postponed from the date selected.
- Payment from a third party, including any foundation, will not be accepted.
- All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.



(9 digits)

Financial Institution Name: Phone #:

Financial Institution Address:

Transit Routing # (from left side of check)	Account # (from right side of check)
_____	_____
X_____ Authorized Signature as Shown on Account _____/_____/_____ Date	X_____ Authorized Signature as Shown on Account _____/_____/_____ Date

Application For: Medicare Supplement Coverage

SECTION 7. AUTHORIZATION AND ACKNOWLEDGEMENT

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

If you are not applying during an open enrollment or guarantee issue period, the following applies: I authorize Combined Insurance Company of America or its reinsurers for the purpose of evaluating this application for insurance to acquire, review, research the release of information from any of the following: Hospital; Physician; Medical Practitioner; Clinic; Pharmacy; Pharmacy Benefits Manager or other pharmacy-related services organization; Health Plan; other medical or medically related facilities; Government Agency; (MIB) Inc.; Consumer Reporting Agency; Combined Insurance's own records; and I authorize any of the foregoing parties that have any records or knowledge of me or my protected health information to give to Combined Insurance or its reinsurers, any such information. Combined Insurance Company of America will acquire through a personal phone interview or another means from the above any needed information on the Insured, his/her dependents including copies of records, concerning advice, care or treatment, on past or present health, the use of drugs or alcohol, and information relating to mental illness. I also authorize Combined Insurance Company of America or its reinsurers to disclose all such information to the MIB, Inc. in order to evaluate an application for insurance or application for reinstatement of insurance. I authorize Combined Insurance Company of America, or its reinsurers to make a brief report of my protected health information to MIB Inc. Federal and state laws protect the information disclosed pursuant to this authorization. I understand that any disclosure of information carries with it the potential for any unauthorized re-disclosure and the information may not be protected by the federal confidentiality rules. I understand this consent may be revoked in writing at any time, with the exception to the extent that disclosure of information has already occurred prior to the receipt of revocation by the above named provider. If written revocation is not received, authorization will be considered valid for a period of two years from the date of signing. A photocopy of this authorization will be as valid as the original. A copy of the authorization is available to you or your representative upon request to the Company. Failure to sign this authorization may impair the ability of Combined Insurance to evaluate or process this application and may be a basis for denying this application.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

Statements in the application are representations not warranties.

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

Dated at _____ , on _____/_____/_____ _____

City State mo / day / yr **Applicant A's Signature**

Dated at _____ , on _____/_____/_____ _____

City State mo / day / yr **Applicant B's Signature**

Application For: Medicare Supplement Coverage

SECTION 7. AUTHORIZATION AND ACKNOWLEDGEMENT, CONTINUED

Premium payment information must accompany application.
I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_____
Agent License Identification No.

X_____ _____
(Signature of Licensed Agent) Date

SECTION 8. FOR ADDITIONAL COMMENTS

Applicant A (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

Combined Insurance Company of America
Administrative Office
PO Box 14207 • Clearwater, FL 33766-4207
Toll-free: 855-278-9329 • www.combinedinsurance.com

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE: SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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

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

STATEMENT TO APPLICANT BY ISSUER, AGENT
I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment:

_____

☐ Other, (please specify) _____

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent, Broker or other Representative	PRINTED Name and Address of Issuer, Agent or Broker
Applicant's Signature	Signature of Applicant B, if applying
Date	Date

Combined Insurance, within five (5) working days from the receipt of an application at its policy issuance office, shall furnish a copy of this notice to the insurer whose policy is being replaced.

RN14905-FL

RETURN TO COMPANY

CERTIFICATION

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. _____ offered by the _____ (Name of Insurance Company) to _____ (Applicant).

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of $ _____ (Insert zero if no premium received) which has been paid to me by ( ) Annual ( ) Semi-annual ( ) Quarterly ( ) Electronic Funds Transfer/Monthly (Check appropriate method of payment).

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services (CMS) in connection with this insurance policy being applied for.

_____ _____

Date Signature of Agent

_____ _____

I, the undersigned applicant, have received a copy of this form

Name of Agency

_____

Address of Agent or Agency

_____ _____

Applicant's signature Phone No.

150005-FL **Return to Company**

CERTIFICATION

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. _____ offered by the _____ (Name of Insurance Company) to _____ (Applicant).

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of $ _____ (Insert zero if no premium received) which has been paid to me by ( ) Annual ( ) Semi-annual ( ) Quarterly ( ) Electronic Funds Transfer/Monthly (Check appropriate method of payment).

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services (CMS) in connection with this insurance policy being applied for.

_____ _____

Date Signature of Agent

_____ _____

I, the undersigned applicant, have received a copy of this form

Name of Agency

_____

Address of Agent or Agency

_____ _____

Applicant's signature Phone No.

150005-FL **Applicant's Copy**

Combined Insurance Company of America

Administrative Office • PO Box 14207, Clearwater, FL 33766-4207

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Combined Insurance (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Combined Insurance, PO Box 14207, Clearwater, Florida, 33766-4207.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Combined Insurance (the Company) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: COMBINED INSURANCE

Receive from_____(Proposed Insured) an application for a Medicare Supplement Policy with Combined Insurance (the Company), and $_____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy issued.

_____	_____	_____
Agent's Name *(please print)*	Agent's Signature	Date

MIB-RECPT-01 05/12

LEAVE WITH APPLICANT

Administrative Office • PO Box 14207, Clearwater, FL 33766-4207
1-855-278-9329

AGENT DISCLOSURE FORM

I, the undersigned insurance agent, represent Combined Insurance Company with regard to the sale of its product(s). I am providing you services on behalf of such insurance company.

I have taken an application for:

_____,
(Applicant(s)),

I certify:

☐ **THAT,** I hold a Florida Resident agent License

Or

☐ **THAT,** I hold a Florida Non-Resident agent License and

☐ I took this sale over the phone, or

☐ I took this application in person in the county of _____ , Florida.

_____ _____
Applicant A Name Applicant B Name

_____ _____
Applicant A's Signature Applicant B's Signature

_____ _____
Date Date

_____
Print Name of Agent

_____
Agent's Signature

_____
Date

RETURN TO COMPANY

150006-FL

Combined Insurance Company of America

Consumers choosing to have initial premiums paid through ACH (Automated Clearing House) for Medicare Supplement Applications may have their initial premium automatically deducted from their checking or savings account through the Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Medicare Supplement applications using ACH for the initial premium:

STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.

Applicants wishing to pay electronically will need to complete the appropriate Medicare Supplement Authorization for Electronic Funds Transfer section on the application and include a voided check.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT 1-866-545-8076

1) ACH fax transmittal cover sheet on the back of this form

2) Medicare Supplement Application and other required forms including authorization for EFT

3) Voided check for EFT

If you fax the application, do not mail it, as processing errors occur and additional charges could result from the duplication.

For producer use only. Not for use with the general public.

Combined Insurance Company of America

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-866-545-8076

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet:_____

Producer Name:_____

Producer Number or NPN:_____

Producer Phone Number:_____

Producer Fax Number:_____

Comments:_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____