MEDICARE SUPPLEMENT

Agent Underwriting

Guidelines for Medicare Supplement

Insurance Company of North America

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Table of Contents

Important contact information:

New Business Mailing address:

Insurance Company of North America
Medicare Supplement Administration
P.O. Box 10856
Clearwater, FL 33757-8856

Overnight Address (FOR USE ON OVERNIGHT MAIL ONLY)
Insurance Company of North America
17757 US HWY 19 N, Suite 660
Clearwater FL 33764

Call **1-866-718-8733** for **Claims, Underwriting, Customer Service and Commissions.**

Underwriting Fax #	1-877-755-7370
New Business Fax #	1-877-373-4562
Claims Fax #	1-727-373-4534

Marketing Support & Agent Licensing 1-866 454-0809 Ext 114582

To access sales and marketing supplies visit the med supp store on the agent portal:
www.inamedsupp.chubb.com

Introduction

This guide provides information about the evaluation process used in underwriting and issuing Medicare Supplement insurance policies. The goal of is to issue insurance policies as quickly and efficiently as possible while assuring proper evaluation of each risk. To accomplish this goal, writing agents will be notified via the agent portal to advise him/her of any problem(s) with an application. All policies and procedures are as of the revision date listed on the front cover and are subject to change.

Policy Issue Guidelines

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. The residence address is what must be populated in the resident address section of the application.

Open Enrollment

To be eligible for open enrollment, an applicant must be at least 64 ½ years of age (in most states) and be within six months of his/her enrollment in Medicare Part B.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month open enrollment period upon reaching age 65.

Selective Issue

Applicants over the age of 65 and at least six months beyond enrollment in Medicare Part B will be selectively underwritten (unless applying in a guarantee issue period). All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any of the non-consideration health questions are answered "Yes," the applicant is not eligible for coverage. Applicants will be accepted or declined.

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.

Eligibility

To determine if the applicant is eligible for coverage, locate the applicant's height, then weight (in pounds) in the chart below. If the applicant's weight is in the Decline column, they are not eligible for coverage at this time. If their weight is located in the Standard weight column, you may continue with the application.

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 +

Application Sign Dates

- Open Enrollment – Up to 90 days prior to the month the applicant turns age 65.
- Wisconsin – Applications can be signed no more than 90 days prior to the applicant's Medicare Part B eligibility date.
- Underwritten Cases – Up to 60 days prior to the requested coverage effective date. During AEP, Annual Open Enrollment Period, underwritten cases may be submitted beginning September 15th.

Coverage Effective Dates

Coverage will be made effective as indicated below:

The effective date of the insurance can be between the 1st and the 28th day of the month. Applications written for an effective date of the 29th, 30th, or 31st of the month will be made effective on the 1st of the next month. Applications may not be backdated prior to the application signed date for any reason to save age. For Open Enrollment applications, the effective date of the insurance policy must be within the 6-month Open Enrollment window.

Replacements

A "replacement" takes place when an applicant wishes to terminate an existing Medicare supplement policy, with another Medicare Supplement plan available, or any other external company and replace with a newer or different Medicare Supplement/Select policy. Internal replacements are processed the same as external, requiring a fully completed application.

A current policyowner wanting to apply for a non-tobacco plan must complete a new application and qualify for coverage.

The policy to be replaced must be in force on the date of replacement. 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.

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.

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

Telephone interviews may be conducted at the discretion of the Underwriter. Please advise your client that we may be contacting them to conduct an interview. Telephone interviews for health information are only conducted for underwritten policies: Open Enrollment and

Guaranteed Issue applicants will not be asked any health questions. If we are unable to complete the telephone interview, we will decline the application.

Pharmaceutical Information

We have implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. In order to obtain the pharmaceutical information as requested, the Authorization and Certification page of the application must be completed and signed by the applicant. Prescription information noted on the application will be compared to the additional pharmaceutical information received.

Policy Delivery Receipt

Delivery receipts are required on all policies issued in Kentucky, Louisiana, Nebraska, South Dakota and West Virginia when the policy is mailed to the agent for delivery.

Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the client. The second copy must be returned to the Company in the self-address envelope, which is also included in the policy package.

Guarantee Issue Rules

The rules listed below can also be found in the Guide to Health Insurance. These are the Federal requirements.

Leaving an employer group voluntarily does not always create applicant eligibility for guarantee issue. In this situation, state laws may vary.

Guarantee Issue Situation	Client has the right to buy. . .
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. Note: In this situation, state laws may vary.	Medigap Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold in their state by any insurance company. If they have COBRA coverage, they can either buy a Medigap policy right away or wait until the COBRA coverage ends.
Client is in the original Medicare Plan and has a Medicare SELECT policy. Client moves out of the Medicare SELECT plan's service area. Client can keep your Medigap policy or he/she may want to switch to another Medigap policy.	Medigap Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold by any insurance company in their state or the state they're moving to.
Client's Medigap insurance company goes bankrupt and the client looses coverage, or client's Medigap policy coverage otherwise ends through no fault of client.	Medigap Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold in their state by any insurance company.

Medicare Advantage (MA)

Medicare Advantage (MA) Annual Election Period

General Election Periods for Medicare Advantage (MA)	Timeframe	Allows for...
Annual Election Period (AEP)	Oct. 15th – Dec. 7th of every year	• Enrollment selection for a MA plan • Disenroll from a current MA plan • Enrollment selection for Medicare Part D
Medicare Advantage Disenrollment Period (MADP)	Jan. 1st – Feb 14th of every year	• MA enrollees to disenroll from any MA plan and return to Original Medicare. • The MADP does not provide an opportunity to: • Switch from original Medicare to a Medicare Advantage Plan. • Switch from one Medicare Advantage Plan to another. • Switch from one Medicare Prescription Drug plan to another. • Join, switch or drop a Medicare medical Savings Account plan.

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 SHIP office for direction.

Medicare Advantage (MA) Proof of Disenrollment

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

Disenroll during AEP and OEP

Complete the MA section on the Medicare supplement application; and send a copy of the applicant's MA plan's disenrollment letter.

If an individual is disenrolling after March 31 (outside AEP/OEP):

Complete the MA section on the Medicare supplement application; and send a copy of the applicant's MA plan's disenrollment letter.

For any questions regarding MA disenrollment eligibility, contact your State Health Insurance Assistance Program (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.

Guarantee Issue Rights

The rights listed below can also be found in the Guide to Health Insurance. These are the Federal requirements. State requirements may vary.

Guarantee 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.	Medigap Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold in their state by any insurance company. They only have this right if they switch to Original Medicare rather than join another Medicare Advantage Plan.
Client joined an MA plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to Original Medicare.	buy any Medigap plan that is sold in your state by any insurance company.
Client dropped his/her Medigap policy to join an MA Plan for the first time, have been in the plan less than a year and want to switch back.	obtain client's Medigap policy back if that carrier still sells it. If his/her former Medigap policy is not available, the client can buy a Medigap Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold in their state by any insurance company.
Client leaves an MA plan because the company has not followed the rules, or has misled the client.	Medigap Plan A, B, C, F, K, or L (if eligible for Medicare prior to 1/1/2020), or A, B, D, G, K or L (if newly eligible for Medicare on or after 1/1/2020) that's sold in their state by any insurance company.

Premium

Calculating Premium

- Determine ZIP code where the client resides and find the correct rate card for that ZIP code
- Determine Plan
- Determine if non-tobacco or tobacco
- Find Age/Gender - Verify that the age and date of birth are the exact age as of the effective date
- Determine if the household discount is applicable. If so, apply the discount first and then the modal factor.
- Use the following Modal Factors to Calculate the Correct Modal Premium based off of the Annual premium rate

  Annual
  Semiannual (Modal factor = 0.50)
  Quarterly (Modal factor = 0.250)
  Monthly* (Modal factor = divide by 12)

  *We do not offer a monthly direct bill option

Household Premium Discount

The eligibility requirements for the Household Premium Discount are:

State	Eligibility
Alabama, Alaska, Arkansas, Arizona, California*, Colorado, Delaware, District of Columbia, Georgia, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Mexico, Nevada, North Carolina, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, West Virginia, Wyoming	• Currently living with spouse OR • Currently have a household resident, who is age 50 or older, with whom has continuously resided for the last 12 months. *California must include validly recognized civil union and domestic partners.
Pennsylvania	• Currently living with spouse OR • Currently have a household resident, with whom has continuously resided for the last 12 months and has or will be applying for and issued INA Med Supp policy.
In addition: Florida, Indiana, New Jersey, Ohio, North Dakota, Oklahoma	• Requires spouse or additional resident(s) to have or will be applying for and issued an INA Med Supp policy.
Household Discount is not offered in Idaho, Minnesota or Vermont.	

When an applicant meets the state's Household Premium Discount eligibility requirements, any existing INA Med Supp policyholder(s) will be given the discount on their next policy billing cycle.

The Household Premium Discount will remain in effect for the life of the policy, except for New Jersey, North Dakota, Ohio and Oklahoma, which require the discount be removed when the eligibility requirements are no longer met.

Completing the Premium on the Application

The payment mode should be selected on the application, with the amount of modal premium indicated in the Premium Collected section. If an application is submitted without premium, the first modal premium and policy fee (if applicable) will be drafted on Issue Date or Effective Date as indicated on the electronic payment authorization form. If neither is selected on the electronic payment authorization form for the Initial Bank Draft, the first modal premium and policy fee will be drafted **upon effective date**.

The available premium payment modes are :

Annual Direct Bill or Annual Bank Draft
Semiannual Direct Bill or Semiannual Bank Draft (Modal factor = 0.50)
Quarterly Direct Bill or Quarterly Bank Draft (Modal factor = 0.250)
Monthly Bank Draft (Modal factor = divide by 12)

Electronic Payment Authorization Form

If paying by bank draft, the Electronic Payment Authorization Form must be completed.

Section 1 allows the applicant to specify a payment preference for both the initial and subsequent premiums. If there is any conflict between the initial draft date selected on the application and the initial draft date selected on the Payment Form, the Payment Form date will be used.

To help policyholders manage their financial matters, the applicant may select a draft date that will coincide with their Social Security deposit date as indicated in the chart below.

	Benefits Paid On
*Birth Date on 1st - 10th	Second Wednesday**
*Birth Date on 11th - 20th	Third Wednesday**
*Birth Date on 21st - 31st	Fourth Wednesday**
Supplemental Security Income (SSI)	1st of the Month**
Beneficiaries who started receiving Social Security Benefits prior to May 1997 or who are receiving both SSI and Social Security	3rd of the Month**

*For beneficiaries who first started receiving social security May 1997 or later
**If date falls on weekend or holiday, payment is made prior business day

The option is also available to draft on a specific day of the month from 1 to 28. If this option is chosen and that day falls on a weekend or holiday the draft will occur the next business day. If a preferred draft day is not selected in section 1, all subsequent premiums will be drafted/charged on effective day.

Refunds

The company will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

Our current administrative practice is not to adjust rates for the initial 12 months from the effective date of coverage.

The Company does not accept post dated checks, cash, agent or agency check, money orders, traveler's checks, initial or renewal premiums from a Third Party Payor that have no family or business relationship to the applicant or Foundations, except where prohibited by law.

Application

A. Application Sections

The Medicare Supplement application consists of seven sections all of which must be completed. Please be sure to review your applications for the following information before submitting.

Section A — Proposed Insured Information

- Please complete the applicant's residence address in full.
- Please complete the applicant's date of birth and age as of effective date. Please remember age and premiums are based on the effective date, not the date the application was signed.
- Medicare card number, also referred to as the Health Insurance Claim (HIC) number, is vital for electronic claims payment
    - For Open Enrollment with a future effective date you can list "unknown" if the claim number is not yet available.
- Height/Weight — required on underwritten cases.

Section B — Plan and Premium Information

- Entire Section must be completed, indicating the plan selected, effective date, Household Discount selection, and premium amount collected.
- When completing the Electronic Payment Authorization Form, current and accurate banking information must be verified.

Section C— Eligibility Questions

The tobacco question must be answered for all underwritten applications. The chart below indicates whether the tobacco question must be answered for open enrollment or guaranteed issue situations.

State	Tobacco question required	State	Tobacco question required	State	Tobacco question required
AL	YES	LA	NO	OK	YES
AK	YES	MD	NO	PA	NO
AR	NO	ME	YES	RI	YES
AZ	YES	MI	NO	SC	NO
CA	NO	MO	NO	SD	YES
CO	NO	MN	YES	TN	NO
DC	YES	MS	YES	TX	YES
DE	YES	MT	YES	UT	NO
FL	YES	NC	NO	VA	NO
GA	YES	ND	NO	VT	NO
IA	NO	NE	YES	WA	NO
ID	YES	NH	NO	WI	NO
IL	NO	NJ	NO	WV	YES
IN	YES	NM	NO	WY	YES
KS	YES	NV	YES		
KY	NO	OH	NO		

- Indicate if the applicant is covered under Parts A and B of Medicare.
- Indicate if the applicant's Medicare Part A and B effective or eligibility dates.
- Indicate if the applicant is applying during a guaranteed issue period, and if so, include proof of eligibility if the answer is yes.

Section D — Health Questions

If the applicant is applying during an open enrollment or a guarantee issue period, do not answer the health questions.

NOTE: In order to be considered eligible for coverage, the initial section of the application health questions that indicate when the applicant is not eligible for coverage must be answered "No" and any "Yes" answers to the subsequent section of health questions where the applicant may be eligible for coverage must be explained and evaluated by an underwriter.

For questions on how to answer a health question, see the Health Questions section of this Guide for clarification.

Section E – Medication History

- Note if applicant is taking any prescription or over-the-counter medications recommended by a physician, list each medication, as well as the original date prescribed, date prescription last filled, dosage and frequency, and diagnosis/ condition the medication is treating.

Section F – Replacement Information

- Verify if the applicant is covered through state Medicaid program.
- If applicant is leaving a Medicare Advantage or Medicare Cost/HMO plan, complete question #3 and include the replacement notice.
- If applicant is replacing another Medicare supplement policy, complete question #4 and include the replacement notice. If question #4 is answered 'yes', question 4b must also be answered 'yes' or a policy cannot be issued. The sale of more than one Medicare Supplement policy is prohibited by law.
- If 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 #5

Please note questions #1, 2, 4, and 5 must always be answered.

B. Authorization and Certification

Signatures and dates: required by the applicant and the writing agent. All agents must be appointed in applicant's resident state and applicant's signature state before a policy can be issued. If someone other than applicant is signing the application (i.e., Power of Attorney (POA)), include copies of the papers appointing that person as the legal representative.

- POA signatures are only allowed for Medicare Supplement applications applying for guaranteed issue or open enrollment. If POA documents are over 12 months old, an affidavit signed by the POA and notarized, except where prohibited by law, is required.
- Indicate Policy Mailing Preference, all policies will be mailed directly from the Company's administrative office to the agent unless otherwise indicated on the application or as state law requires.

Declined Applications

Applications Will Be Declined For The Following Reasons:

- The applicant does not recall filling out the application.
- A family member filled out the application and the family member signed the application.
- A POA or other representative signed the application when the applicant was not in a Medicare Supplement Open Enrollment or Medicare Supplement Guaranteed Issue period.
- The application was taken by an agent who was not licensed and appointed at the time of solicitation in the state of solicitation.
- The applicant is unable or unwilling to complete the telephone interview.
- If additional forms requested by the underwriter are not submitted within the allotted timeframe.
- If the client is taking any of the drugs listed on the Medication guideline for the condition listed. (See Medication list section in this guide).
- If the application was submitted with a premium check from a third party payor that has no family or business relationship to the applicant, except where prohibited by law. **Please note, renewal premium payments will not be accepted from a third party payor that has no family or business relationship to the applicant or Foundations, except where prohibited by law.**
- If the applicant is replacing a Medicare Advantage Plan and is unable to provide proof of disenrollment from the Medicare Advantage Plan.
- If an applicant cannot provide the medical condition that a prescribed medication is treating and is unable to obtain the information from their physician
- If the applicant is deemed uninsurable after completing our underwriting process.

Applicants requesting the reason for declination

- If the reason for decline was non-medical or came directly from the application, we are able to release this information verbally to both the agent and applicant.
- If the reason for decline came from information the applicant disclosed during the phone interview, we will advise the applicant verbally or send "the reason for decline letter" directly to the applicant only. This request can be made verbally or in writing.
- If the reason for decline came from the prescription drug history, the adverse underwriting letter that is mailed to the applicant will contain the medical condition or conditions that may be likely based on the prescription drug report or admitted drug history from the application. The applicant may request a copy of their drug report and review the medications and reason prescribed with their physician. Any inaccuracies with the prescription drug report will need to be addressed with the prescription drug report vendor.
- If the reason for decline came from medical records or information obtained directly from a physician – we will only release the reason for declination to a physician of the applicant's choice. This request should be in writing indicating the name, address and phone number of the physician and signed by the applicant.

Decline Appeals

If the applicant wishes to appeal his/her declined application, a written request must be submitted by the applicant to the Underwriting Manager within 60 days of the decision. If more than 60 days have passed since the decline, the applicant will be required to submit a new application and a telephone interview will be completed.

All appeals require five years of medical records from the applicant's primary care physician. It is the responsibility of the applicant to obtain his/her medical records. Medical records must be submitted to the Underwriting Department directly from the physician's office and will not be accepted if submitted by the applicant or agent. Please note that Insurance Company of North America does not reimburse any fees associated with obtaining medical records or other supporting documentation pertaining to the requested appeal.

The written request and medical records may be faxed to 1-877-755-7370 and directed to the attention of the Medicare Supplement Underwriting Manager. The request and records may also be mailed to the physical address or post office box noted on the Important Contact Information section at the beginning of this Guide.

Withdrawn Applications

An applicant can request to withdraw their application anytime during the underwriting process in writing or verbally via a recorded statement with one of our representatives. The writing agent will be contacted when notification is received indicating the applicant wishes to have their application withdrawn. The writing agent will be given 10 business days in which to try to conserve the business.

If an applicant's premium check is returned by their financial institution, the application will be processed as Withdrawn (a returned check is considered written notification of

the applicant's intent to withdraw their insurance application). The writing agent is not contacted about conserving the business in this situation.

A full refund of the premium submitted with a withdrawn application will be processed 21 days after the date the check was deposited (to ensure the check has cleared the bank). If an applicant requests the refund prior to that, the applicant's financial institution will be contacted to verify the check has cleared. The refund check and a letter confirming the application was withdrawn will be mailed to the applicant.

If an application was submitted without premium a letter confirming the application was withdrawn will be mailed to the applicant.

Not Taken Insurance Policies

Applicants who have received an insurance policy without any outstanding delivery requirements will need to provide a signed written notice of their request not to take their issued insurance policy. The request can be in the form of the returned insurance policy appropriately marked they do not wish to keep the insurance policy or may be in the form of a signed letter or other written statement.

If the applicant was mailed an insurance policy with outstanding delivery requirements, and the delivery requirements are not received within the allotted timeframe, the insurance policy will be considered Not Taken and processed as such.

An applicant with a Not Taken insurance policy should be encouraged to return the insurance policy if they have not already done so.

In order to receive a full refund of premium, the request not to take the insurance policy must be either post-marked (if sent via mail) or received by our administrative office (if faxed) within the 30-day free look period. A full refund of the premium for Not Taken insurance policies will be processed 30 days after the date the check was deposited (to ensure the check has cleared the bank). If the applicant requests the refund prior to that, the applicant's financial institution will be contacted to verify the check has cleared.

State specific special enrollment period rules:

State	Rule
CA	Beginning on a person's birthday and lasting 60 days, a person may purchase any Medicare Supplement policy that offers benefits equal to or lesser than those provided by the previous coverage.
ID	An individual can voluntary terminate a Medicare Supplement policy beginning on the individual's birthday and enroll in another Medicare Supplement policy of equal or lesser benefits. The application must be signed no more than 63 days after the applicant's birthday. The earliest effective date available is the applicant's birthday and the latest effective date is no more than 63 days after. Applications can be signed 60 days prior to the requested effective date.
IL	An individual that is at least 65 years of age and no more than 75 years of age that has an existing Medicare Supplement policy is entitled to an annual open enrollment period that lasts 45 days beginning on the individual's birthday may purchase any Medicare Supplement policy with the same issuer (same company) that offers benefits equal to or lesser than those provided by the previous coverage. This new birthday rule is effective January 1, 2022 and will not apply to an individual until their birthday in 2022.
KY	An applicant that is within 60 days of their birthday can apply for the same Medicare Supplement plan that they are currently enrolled with a different insurer. The effective date must fall on the applicant's birthday or up to 60 days after the birthday and must be within 30 days of the application sign date.
LA	An individual that has an existing Medicare Supplement policy is entitled to an annual open enrollment period that lasts 63 days beginning on the individual's birthday may purchase any Medicare Supplement policy with the same issuer (same company) or any affiliate that offers benefits equal to or lesser than those provided by the previous coverage.
MD	Beginning on a person's birthday and up to 30 days after, a person may purchase any Medicare Supplement policy that offers benefits equal to or lesser than those provided by the coverage being replaced. The earliest effective date available is the applicant's birthday and the latest effective date is no more than 30 days after. Applications can be signed 60 days prior to the requested effective date.
ME	The individual is covered under a Medicare Supplement policy and has been covered under a policy that supplemented benefits under Medicare or has been covered under a Medicare Advantage plan with no gap in coverage greater than 90 days beginning with the person's open enrollment period.
MO	Enrolled in a Medicare Supplement policy and the individual is adhering to Missouri Annual Anniversary rule. Plan availability for this scenario is to move from the "same plan" to the "same plan". The earliest effective date available is 30 days prior to the current Medicare Supplement's annual anniversary and the latest effective date is 30 days after the current Medicare Supplement's annual anniversary. Applications can be signed 60 days prior to the requested effective date.

NV	Beginning on the first of day of a person's birth month and for 60 days after the person's birthday, a person enrolled in a Medicare supplement policy may cancel the existing Medicare supplement and purchase another Medicare supplement with the same or lesser benefits to replace the existing Medicare supplement. This is effective January 1, 2022.
OK	Annually, beginning on a person's birthday and for up to 60 calendar days after, a person who has a Medicare Supplement policy, including a person entitled to Medicare benefits due to disability, and has had no gap in coverage greater than 90 days since the last enrollment period of their existing policy, shall be provided continuity of coverage under a new supplement policy with the same or lesser benefits issued by the same or different issuer. The earliest effective date available is the applicant's birthday and the latest effective date is 60 days after. Applications can be signed 60 days prior to the requested effective date.
OR	Beginning 30 days prior to a person's birthday and for 30 days after the person's birthday, a person enrolled in a Medicare supplement policy may cancel the existing Medicare supplement and purchase another Medicare supplement with the same or lesser benefits to replace the existing Medicare supplement.
UT	An individual that is enrolled in a Medicare Supplement policy is entitled to an annual birthday open enrollment period beginning on the individual's birthday and ending 60 days later, an issuer shall allow an enrollee that is enrolled in one of the issuer's Medicare Supplement plans to choose a different plan with the same issuer (same company) that offers benefits equal to or lesser than those provided by the previous coverage. This rule is effective for application signed 5/7/2025 and later.
VA	An insurer issuing individual Medicare supplement policies or certificates in the Commonwealth, shall offer to an individual currently insured under any such policy or certificate an annual open enrollment period commencing on the day of the individual's birthday and remaining open for at least 60 days thereafter, during which time the individual may purchase any Medicare supplement policy made available by any insurer in the Commonwealth that offers the same benefits as those provided by the current coverage. Innovative benefits shall not be considered when determining whether a Medicare supplement policy includes the same benefits as those provided by the previous coverage. The earliest effective date available is the applicant's birthday and the latest effective date is 60 days after. Applications can be signed 60 days prior to the requested effective date. This rule is effective for applications signed 7/1/2025 and later.
WA	Enrolled in a Medicare Supplement Plan A, B, C, D, F, G, K, L, M or N (including high deductible plans) for at least 90 days. The effective date must be more than 90 days after the effective date of the plan being replaced and the application can be signed no more than 60 days prior to the requested effective date.
WY	An annual 63 day guaranteed issue period, beginning on the enrollee's birthday, where the applicant terminates enrollment in an existing Medicare Supplement policy and enrolls in another Medicare Supplement policy of equal or lesser benefits with a different insurer. The effective date must fall on the applicant's birthday or up to 63 days after the birthday. The application can be signed up to 60 days prior to the requested effective date.

Health Questions

Unless an application is completed during open enrollment or a guarantee issue period, 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." For a list of uninsurable conditions and the related medications associated with these conditions, please refer to the section below.

Consideration for coverage may be given to those persons with well-controlled cases of diabetes with hypertension. A case is considered well-controlled if the person is taking less than 50 units of insulin daily, or no more than two oral or injectable medications for diabetes and no more than three medications for hypertension. We consider hypertension stable if recent average high blood pressure readings are 150/90 or lower, treated or untreated. Combo medications for diabetes or hypertension will count as 2 independent medications.

Applicants with diabetes that have ever required more than 50 units of insulin daily, or applicants with diabetes (insulin-dependent or treated with oral medications) who also have one or more of the complication conditions listed in this question of the application are not eligible for coverage.

Below are some complications that are indicators that the client's diabetes is not well-controlled:

- Pain or swelling in the feet (edema linked to Congestive Heart Failure (CHF), pulmonary conditions, venous insufficiency)
- Loss of feeling or tingling in the extremities
- Last 3 A1c readings average to be greater than 7.5 or the readings are trending upwards above 7.5
- Has been advised to see a Nephrologist
- A history of blood clots
- Circulation problems such as Neuropathy
- Taking 3 or more medications (oral or injections) to control blood sugar. Combination medications count as two individual medications
- Taking 4 or more medications (oral or injections) to control hypertension when diabetes is present. Combination medications count as two individual medications
- Diabetic eye diseases such as retinopathy, macular edema, or blurry vision attributed to uncontrolled blood sugar

Applicants with heart and/or circulatory conditions may be considered for coverage provided it has been more than 2 years since the diagnosis or occurrence of the event. In addition to verify stability below are some general guidelines that outline when an application should not be submitted:

- A history of blood clots
- A history of a heart or circulatory condition and the applicant is taking more than 60mg of Lasix

- The applicant has an increase in dosage or frequency of a prescription medication that is taken to treat a heart or circulatory condition
- Taking 4 or more blood pressure medications in combination with a heart or circulatory condition.
- Used Nitroglycerin in the last 12 months
- Been to the emergency room, urgent care or been hospitalized for a heart or circulatory condition within the past two years
- Been advised to have surgery, procedures, or additional tests for a heart or circulatory condition that has not been performed
- If the frequency of any heart medication (or injection) is more than once a day
- For those applicants with peripheral vascular disease, peripheral venous thrombotic disease and/or carotid artery disease, those applicants that require assistance with walking

Degenerative bone disease, spinal stenosis, and crippling/disabling and rheumatoid arthritis are medical conditions determined by many factors. Some additional field underwriting questions/observations are listed below to help you determine if the application should be submitted:

- The application should not be submitted if the applicant requires assistance with completing their activities of daily living such as dressing, bathing, eating, housework or shopping
- The application should not be submitted if the applicant requires assistance in walking or uses any aides for walking such as a cane, walker, wheelchair or if hands on assistance is provided by another person
- The application should not be submitted if the applicant is seeing a chiropractor for one of these conditions and visits exceed more than 2 per month
- The application should not be submitted if the applicant has had a surgery or procedure for one of these conditions within the past 2 years
- The application should not be submitted if the applicant has been diagnosed with Osteoporosis or Osteoarthritis and has a history of a fracture.
- The application should not be submitted if the applicant is currently receiving, considering or has been advised to have physical therapy

An applicant with a mental or nervous disorder requiring treatment from a psychiatrist can be submitted for review considering the following:

- The applicant is taking no more than 3 medications for depression within the last two years
- The applicant was diagnosed with the mental or nervous disorder more than two year ago
- The applicant is seeing a psychiatrist more than one time a week or the visits have increased in the last year
- The applicant has had an increase is dosage or frequency of any medication taken for a mental or nervous disorder
- The applicant has attempted suicide
- The applicant has had an emergency room, urgent care or been hospitalization due to a mental or nervous disorder

An applicant that is currently receiving, advised to received or has received injections in a physician's office can be submitted for review consider the following:

- The applicant has had a biannual (or less) cortisone injection for the treatment of Osteoarthritis within the past 12 months

Uninsurable Health Conditions

Applications should not be submitted if applicant has the following conditions:

AIDS / HIV / ARC (AIDS related complex)

Alzheimer's Disease or Dementia

ALS (Amyotrophic Lateral Sclerosis / Lou Gehrig's Disease

Cirrhosis

Chronic Obstructive Pulmonary Disease (COPD)

Other chronic pulmonary disorders to include:

- Chronic bronchitis
- Chronic obstructive lung disease (COLD)
- Chronic asthma
- Chronic interstitial lung disease
- Chronic pulmonary fibrosis
- Cystic fibrosis
- Sarcoidosis
- Bronchiectasis
- Scleroderma
- Emphysema

Chronic Kidney Disease (stages 3-5) or Renal Failure requiring dialysis

- Arthritis that restricts mobility

Diabetes with > 50 units of insulin per day or requiring 3 or more medications[1] (oral or injection) to control blood sugar.

Diabetes with vascular disease (coronary, carotid, peripheral) or kidney disease.

Diabetes with 4 or more medications[1] to treat blood pressure.

Schizophrenia

Lupus - Systemic

Multiple Sclerosis (MS)

Muscular Dystrophy

Myasthenia Gravis

Organ transplant (stem cells included; corneal transplants excluded)

Osteoporosis with fracture

Parkinson's Disease

Pulmonary Arterial Hypertension / Pulmonary Hypertension

Other cognitive disorders to include

- Mild cognitive impairment (MCI)
- Delirium
- Organic brain disorder

Scleroderma

Chronic Hepatitis

Lambert-Eaton Syndrome

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

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Advised to have surgery, medical tests, treatment or therapy
- If applicant's height/weight is in the decline column on the chart
- Any applicant that has been referred for further diagnostic testing or consultation with an additional physician that has not been completed.
- Any applicant prescribed more than five opioid medications in the last 24 months.
- Currently living in a nursing home or assisted living facility

Medication Guideline

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications: (this section can vary depending on the health questions)

Generic	Brands	Uninsurable Health Condition
abacavir	Ziagen	HIV
abarelix	Plenaxis	cancer
acamprosate	Campral	alcohol abuse
AL-721	AL-721	AIDS, HIV
albuterol/ipratropium	DuoNeb, Combivent Respimat	COPD, emphysema
altretamine	Hexalen	cancer
amantadine	Endantadine, Symmetrel, Symadine	Parkinson's
anakinra	Kineret	rheumatoid arthritis
apomorphine	Apokyn, Uprima	Parkinson's
atazanavir	Reyataz	HIV
auranofin	Ridaura	rheumatoid arthritis
aurothioglucose	Solganal	rheumatoid arthritis
azathioprine	Imuran, Azasan	rheumatoid arthritis, kidney transplant
BCG	TheraCyx, Tice BCG	bladder cancer
baclofen	Lioresal, Lioresal Intrathecal, Gablofen	multiple sclerosis
benztropine	Cogentin	Parkinson's
bicalutamide	Casodex	prostate cancer
biperiden hydrochloride	Akineton	Parkinson's
bleomycin	Blenoxane	cancer
bromocriptine	Cycloset, Parlodel	Parkinson's
busulfan	Myleran, Busulfex	cancer
carbidopa	Lodosyn	Parkinson's
carbidopa/levodopa	Sinemet, Rytary, Duopa, Atamet, Carbilev, Parcopa	Parkinson's
carboplatin	Paraplatin	cancer
chlorambucil	Leukeran	cancer, kidney transplant, rheumatoid arthritis
chlorotrianisene	Tace	cancer
chlorpromazine	Thorazine	psychosis, schizophrenia
cisplatin	Platinol	cancer
cyclophosphamide	Cytoxan, Neosar	cancer, rheumatoid arthritis, lupus
cycloserine	Seromycin	tuberculosis
cyclosporine	Neoral, Sandimmune, Gengraf	organ transplant, cancer, rheumatoid arthritis
darunavir	Prezista	AIDS, HIV
delavirdine	Rescriptor	AIDS, HIV
didanosine	Videx, ddI	AIDS, HIV
disulfiram	Antabuse	alcohol abuse
donepezil	Aricept	dementia
doxorubicin	Adriamycin, Caelyx, Rubex	cancer
dronabinol	Marinol, THC	cancer
efavirenz	Sustiva	AIDS, HIV
emtricitabine	Atripla	AIDS, HIV
emtricitabine	Emtriva, Coviracil	AIDS, HIV

Generic	Brands	Uninsurable Health Condition
emtricitabine/tenofovir	Truvada	HIV
enfuvirtide	Fuzeon	AIDS, HIV
entacapone	Comtan	Parkinson's
entacapone/levodopa/ carbidopa	Stalevo	Parkinson's
epoetin alfa	Epogen, Procrit, Eprex	chronic kidney disease, HIV, cancer
ergoloid mesylates	Hydergine	dementia
etanercept	Enbrel	rheumatoid arthritis
ethinyl estradiol	Estinyl	cancer
ethopropazine	Parsidol	Parkinson's
etoposide	VePesid, Toposar, Etopophos	cancer
filgrastim	Neupogen, Granix, Zarxio	cancer
fluphenazine	Modecate, Prolixin, Moditen, Permitil	psychosis
flutamide	Euflex, Eulexin	cancer
fosamprenavir	Lexiva	HIV
foscarnet sodium	Foscavir	AIDS, HIV
furosemide (>60mg/day)	Lasix	heart disease
galantamine	Razadyne, Reminyl	dementia
glatiramer	Copaxone, Glatopa	multiple sclerosis
gold sodium thiomalate	Myochrysine, Aurolate	severe arthritis
goserelin	Zoladex	cancer
haloperidol	Haldol, Peridol	psychosis
hydroxyurea	Hydrea, Droxia	cancer
imatinib	Gleevec	cancer
indinavir	Crixivan, IDV	AIDS, HIV
infliximab	Remicade	rheumatoid arthritis
insulin > 50 units per day	many brands	diabetes mellitus
interferon	many brands	AIDS, HIV, cancer, multiple sclerosis, hepatitis
interferon alfa-2a	Roferon-A	AIDS, HIV, cancer
interferon beta 1a	Avonex, Rebif	multiple sclerosis
interferon beta 1b	Betaseron, Extavia	multiple sclerosis
ipratropium	Atrovent	COPD, emphysema
lamivudine	Combivir, 3TC, Epivir	AIDS
lamivudine/zidovudine/ abacavir	Trizivir	HIV
leuprolide	Lupron, Eligard	cancer
levamisole hydrochloride	Ergamisol	cancer
levodopa	Larodopa, Dopar, L-Dopa	Parkinson's
lomustine	Gleostine, CCNU	cancer
lopinavir	Kaletra	HIV
maraviroc	Selzentry	HIV
medroxyprogesterone acetate	Depo-Provera, Provera, Amen, Curretab, Cycrin	cancer
megestrol	Megace	cancer
melphalan	Alkeran	cancer
memantine	Namenda	dementia
methotrexate	Trexall, Rheumatrex, Rasuvo, Otrexup	severe arthritis (>25mg/wk), cancer

Generic	Brands	Uninsurable Health Condition
mitomycin	Mutamycin	cancer
mitoxantrone	Novantrone	multiple sclerosis, cancer
mycophenolate	CellCept, Myfortic	myasthenia gravis, organ transplant
naltrexone	ReVia, Vivitrol, Depade	opioid or alcohol detox
natalizumab	Tysabri	multiple sclerosis
nelfinavir	Viracept	AIDS, HIV
neostigmine	Prostigmin, Bloxiverz	Myasthenia Gravis
nesiritide	Natrecor	congestive heart failure
nevirapine	Viramune	AIDS, HIV
ondansetron	Zofran	cancer
oxygen		COPD, emphysema
paliperidone	Invega	schizophrenia
pergolide mesylate	Permax	Parkinson's
pramipexole	Mirapex	Parkinson's
prednisone	Rayos, Sterapred	severe arthritis (>10mg/day), lupus, chronic lung disease
procyclidine	Kemadrin	Parkinson's
pyridostigmine	Mestinon, Regonol	Myasthenia Gravis
rasagiline	Azilect	Parkinson's
riluzole	Rilutek	ALS - amyotrophic lateral sclerosis
risperidone	Risperdal	psychosis, schizophrenia
ritonavir	Norvir	AIDS, HIV
rivastigmine	Exelon	dementia
ropinirole	Requip	Parkinson's
rotigotine	Neupro	Parkinson's
saquinavir	Invirase, Fortovase	AIDS, HIV
selegiline	Carbex, Eldepryl, Zelapar	Parkinson's
stavudine	Zerit, d4T	AIDS, HIV
streptozocin	Zanosar	cancer
tacrine	Cognex	dementia
tacrolimus	Prograf, Hecoria, Astagraf, Envarsus	myasthenia gravis, organ transplant
tenofovir	Viread	AIDS, HIV
testolactone	Teslac	cancer
theophylline	many brands	COPD, emphysema
thioridazine	Mellaril	psychosis, dementia
thiotepa	Tespa, Thioplex	cancer
thiothixene	Navane	psychosis
tiotropium	Spiriva	COPD, emphysema
tipranavir	Aptivus	AIDS, HIV
tolcapone	Tasmar	Parkinson's
trastuzumab	Herceptin	cancer
trifluoperazine	Stelazine	psychosis, schizophrenia
trihexyphenidyl	Artane, Trihex	Parkinson's
triptorelin	Trelstar	cancer
valganiciclovir	Valcyte	HIV
vincristine	Oncovin, Vincasar	cancer
zalcitabine	Hivid, ddC	AIDS, HIV
zidovudine	AZT, ZDV, Retrovir	AIDS, HIV, hepatitis

Generic	Brands	Uninsurable Health Condition
ziprasidone	Geodon	schizophrenia
zoledronic acid	Reclast, Zometa	hypercalcemia caused by cancer

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 the Company and attached to the policy to make it part of the contract.

Electronic Payment Authorization Form

If premiums are paid by automatic bank draft, complete this form. Current and accurate banking information must be verified when completing the Electronic Payment Authorization Form.

Replacement Form

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

Amendments

An Amendment to the application will be generated for the following reasons:

- Any question left blank (a new application will be required if four or more questions are left blank)
- Any question answered incorrectly on the application (as determined in the phone interview)
- An error or unclear answer for the date of birth, plan being applied for or underwriting risk classification
- Application sign date is left blank or is altered
- The “signed at” information is left blank or is incorrect
- An error or unclear answer for modal premium

> The use of amendments is not permitted in Kentucky and Minnesota. Any corrections needed to an application will need to be made prior to policy issuance.

State Special Forms

Forms specifically mandated by the states to accompany the application.

Illinois

Illinois Checklist must be completed and submitted with all applications in Illnois.

Kentucky

Medicare Supplement Comparison Statement – The Comparison Statement must be completed and submitted when replacing a Medicare supplement or a Medicare Advantage plan.

Ohio

Agent Medicare Supplement Insurance Solicitation Notice - must be completed and submitted with all applications in Ohio.

South Carolina

Duplication of Insurance form – The duplication of insurance form must be completed and signed when the applicant has coverage under any other health plan within the past 63 days.