

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Seniors with Medicare Parts A and B



Section 1 – Choice of Coverage

Please check the box for your choice of coverage:

- Standard Plan A Standard Plan B Standard Plan C Standard Plan D

Section 2 – Application Information

This complete original application will be returned to you, for your records, along with your policy, when you are enrolled.

Please copy the information from your Medicare card here ↓

NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
_____	_____	_____
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE (PART A)	_____	
MEDICAL INSURANCE (PART B)	_____	

Requested effective date or end date of prior Medicare supplement, if replacing _____

Name (as it appears on your Medicare card) _____

Social Security Number

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 Date of Birth _____

Home Address, Apt. No., Suite No. _____

City _____ County _____ State _____ Zip _____

Home Telephone Number _____

Billing Address, (if different from home address) _____

City _____ County _____ State _____ Zip _____

Care of/Attention _____

Section 3 – Billing Information

- Quarterly Semi-annual Annual
 Monthly Debit (Complete Monthly Checking Deduction Authorization Form)

New Era Use Only
Broker Number _____
H/S <input type="checkbox"/> Yes <input type="checkbox"/> No
Amount Received \$ _____
Policy No. _____ Effective Date _____

Affix check here. Please make check or money order for premium payable to New Era Life Insurance Company.

No agency checks are accepted.

Applicant: Please return application to agent or to the mailing address below:

New Era Life Insurance Company, Underwriting Department

P.O. Box 4884

Houston, Texas 77210-4884

Section 4 – Health History

THIS SECTION MUST BE COMPLETED BY APPLICANT UNLESS APPLYING DURING THE OPEN ENROLLMENT PERIOD OR UNDER GUARANTEED ISSUED PROVISIONS (Skip to Section 5). SEE ATTACHED DEFINITION OF PERSONS ELIGIBLE FOR GUARANTEED ISSUE.

If the answer to any of the following questions is "Yes", you are not eligible for coverage.

Check the box next to any conditions that apply to you.

- | | Yes | No |
|--|--------------------------|--------------------------|
| 1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair for any daily activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 2 years, have you been advised by a member of the medical profession to have surgery which has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past 5 years, have you ever experienced, been diagnosed by a member of the medical profession, consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions: | | |
| a. heart conditions including but not limited to heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder, or other senility disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, or emphysema (excluding allergies)? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea), amputation or joint replacement due to disease? | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant's Initials _____

Section 5 – Physician Information

Name of Primary Care Physician _____ Telephone (____) _____

Address _____

Section 6 – General Information

ANSWER ALL QUESTIONS IN THIS SECTION

To the best of your knowledge;

Did you turn age 65 in the last 6 months? Yes No

Did you enroll in Medicare Part B in the last 6 months? Yes No

If yes, what is the effective date?

Are you covered for medical assistance through the state Medicaid program? Yes No

[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,

(a). Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(b). Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ____/____/____ END ____/____/____

If yes, and you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

Was this your first time in this type of Medicare Plan? Yes No

Did you drop a Medicare supplement policy to enroll in the Medicare Plan? Yes No

Do you have another Medicare supplement policy in force? Yes No

If so, with what company and what plan do you have? _____

If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan?) Yes No

If so, with what company and what kind of policy?

What are your dates of coverage under this policy? (If you are still covered under this plan, leave "END" blank.)

START ____/____/____ END ____/____/____

Tobacco Usage

Have you used any form of tobacco within the past 5 years? * Yes No

I acknowledge that misrepresentation of this information may render the policy null and void.

Date: _____
Applicant's Signature

***Note: You are not required to answer this question if you are applying during open enrollment or if you are eligible for guaranteed issue.**

Section 7 – Conditions of Application

Please read the following carefully.

1. I agree to submit the premium required for the plan requested with this application. Such premium (not including the non-refundable fee) will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. If New Era disapproves my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that under no circumstances will any New Era benefits be payable. **Cashing of my check by New Era does not constitute approval of my application.**
3. If my application is accepted, this application will become part of the agreement between New Era and myself.
4. The selling agent has no authority to promise me coverage or to modify New Era underwriting policy or terms of any New Era coverage.
5. I have read and accurately completed this application. To the best of my knowledge I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that New Era may void all coverage from the original effective date of the policy for material misstatements or omissions.

Section 8 – Authorization and Agreements

FRAUD NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.

Notice to Applicant

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this 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 the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. 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).
6. 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 reinstated if requested within 90 days of losing your employer or union-based group health plan.

Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization Form For Your Files If Requested. (Read all five paragraphs and sign below)

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of New Era Life Insurance Company any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize New Era, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable New Era to process claims. A photocopy shall be valid.
- I understand and agree to the Replacement Notification, the Conditions of Application and the Authorization. I acknowledge receipt of the “Guide to Health Insurance for People with Medicare” or “Medicare and You”, and “Outline of Medicare Supplement Coverage and Premium Information” as required. I understand that receipt of money with this application does not create New Era coverage. Coverage will come into effect only if this application is approved by New Era.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

X

Applicant's Signature

Date of Signature

ELIGIBILITY FOR GUARANTEED ISSUE

If you are applying for coverage prior to or during the 6-month period beginning with the first day of the first month in which you enrolled for benefits under Medicare Part B, then you are eligible for the open enrollment. If not, but you have lost or are losing other coverage, you may be eligible for guaranteed issue.

This information can help you determine if you are eligible for guaranteed issue. In order to be eligible for guaranteed issue, one of the following situations must apply and you must provide certain information to document the termination of, disenrollment from certain Medicare plans, Medicare Supplement plans or other coverage. The company terminating your plan is required to notify you, in writing, of the termination of the plan and the reason for termination.

You are eligible for guaranteed issue of plans A, B, C, F, including High Deductible F, K or L (we offer plans A, B, C, and D only in your state) if:

1. During the past 63 days, an Employee Welfare Benefit Plan: a) that was supplemental to Medicare either terminated or stopped providing health benefits to you; or b) that was primary to Medicare either terminated or stopped providing health benefits to you because you left the plan.
2. Within the past 63 days, your Medicare Advantage Plan, Program of All-Inclusive Care for the Elderly (PACE), Medicare Cost Plan, health care pre-payment plan, or a similar organization operating under demonstration project authority or Medicare Select Plan:
 - a) terminated because its certification terminated;
 - b) terminated or otherwise discontinued in the area in which you live;
 - c) terminated because you changed your place of residence which caused you to no longer be eligible for the plan;
 - d) terminated because the provider substantially violated a material provision of the plan, such as the failure to provide, on a timely basis, medically necessary care for which benefits are available or failure to provide such covered care in accordance with applicable quality standards;
 - e) terminated because the plan, agent or other entity acting on the plan's behalf materially misrepresented the plan's provisions in marketing the plan to you;
 - f) terminated because of other exceptional conditions for the termination of the plan.
3. Within the past 63 days, your Medicare Supplement policy:
 - a) terminated because of the insolvency of the issuer or bankruptcy of the non issuer company or of other involuntary termination of coverage;
 - b) terminated because the company issuing the Medicare supplement policy substantially violated a material provision of the policy;
 - c) terminated because the company, agent or other entity acting on the organization's behalf materially misrepresented the Medicare Supplement policy's provision in marketing the plan to you.
(NOTE: An increase in premium does not constitute a violation of a material provision of the policy or a material misrepresentation of the policy.)
4. Within the past 12 months, you terminated Medicare Supplement coverage to enroll, for the first time, in a Medicare Advantage Plan, Medicare Cost Plan, or any similar organization operating under demonstration project authority, any Program of All-Inclusive Care for the Elderly (PACE) or any Medicare Select Plan and you terminated that plan within the past 63 days.

You are eligible for guaranteed issue of any plan we offer in your state if:

Within the past 12 months and upon first becoming eligible for benefits under Medicare Part A and enrolled in Part B of Medicare, you enrolled in a Medicare Advantage Plan under Part C of Medicare, or enrolled in a PACE provider under section 1894 of the Social Security Act and disenrolled from the plan or program within 12 months after the effective date of enrollment.

MEDICARE SUPPLEMENT PLAN REPLACEMENT WORKSHEET

Agents please complete if replacing other existing Medicare coverage

Insured

Name	SS#
Proposed Plan	

Old Plan

Company Name	
Expiration Date	Contract No.

Benefit Comparison

See reverse side for New Era benefits. Check benefits that apply.
Write in benefits not listed.

	Old Plan	New Era Plan
Part A Deductible		
Part A Coinsurance		
Additional Hospital Days		
Skilled Nursing Facility Coinsurance		
Part B Deductible		
20% Part B Coinsurance		
50% Part B Coinsurance (Nervous and Mental)		
Part B Excess Charges at 100%		
Prescription Drugs		
Emergency Travel Benefits Outside the U.S.		
At-Home Recovery		
Preventive Medical Care		
10% or Greater Premium Savings		

Does this plan have benefits clearly substantially better than those of the old plans? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, explain below: _____ _____ _____
Agent Signature _____ Agent No. _____ Date _____

Optional Monthly Checking Deduction Authorization

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of New Era Life Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize New Era to initiate debits (and/ or corrections to previous debits) from my account with the financial institution indicated for payment of my New Era premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no obligation whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Insured	Social Security Number
	Bank Name
X _____ Date	X _____ Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

AGENT WORKSHEET

Does Your Plan Cover	Plan A	Plan B	Plan C	Plan D
Part A Deductible		X	X	X
Part A Coinsurance	X	X	X	X
Additional Hospital Days (150-515)	X	X	X	X
Part B Deductible			X	
20% Part B Coinsurance	X	X	X	X
50% Part B Coinsurance (Nervous and Mental)	X	X	X	X
Part B excess Charges at 100%				
Prescription Drugs				
Emergency Travel Benefits Outside U.S.			X	X
At-Home Recovery				X
Preventive Medical Care				
Basic Prescription Drug (\$1,250 Limit)				

PRIORITY PROCESSING

Complete this form to enroll in the
Optional Monthly Checking Account Deduction
Authorization for Seniors.

Include a blank check marked "VOID".

A deposit slip is not acceptable.

New Era Life

Senior Services
Toll-Free Number



Monday – Friday
8:00 a.m. to 5:00 p.m.

(877) 368-4691

For Agent Only

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr. _____	_____	Name _____
To: Mo./Yr. _____	_____	Address: _____
	_____	City/State: _____

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

SIGNED AT

Agent's Signature _____ Date of Signature _____ (City and State) _____

Print Agent's Name _____ Agent No. _____

Street Address _____ Telephone No. _____

City _____ State _____ ZIP _____

Premium Amount \$ _____

Send Policy To: Agent Insured

The I.D. Card will be sent to the agent or insured in a separate mailing.

Senior Services Toll-Free Number

Monday-Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)

(877) 368-4691



PREMIUM RECEIPT

Date _____ Modal premium _____

Plus one time Non-refundable application fee _____

Equals Total amount submitted with application _____

Name _____

Social Security Number _____

Account _____ Check Number _____

Policy Description _____

Received by _____

This is a receipt for cash received only. It does not guarantee insurance coverage.