First Name Last Name

3 Is your acceptance guaranteed? (continued)

3C. Have you lost or are losing health insurance coverage or do you have a Medicare Advantage Plan "trial right" and, if so, have you received a notice from your employer or prior insurer saying that you are eligible for guaranteed issue of a Medicare supplement plan?

☐Yes ☐No

If you have a guaranteed issue right, you must provide a copy of the notice, disenrollment letter or other documentation you received AND your Application Form must be received no more than 63 days after the termination date of your prior coverage. The documentation should include the type of coverage being lost, the termination reason, the termination date and the name of the person(s) who lost or is losing coverage.

If you have questions about guaranteed issue rights, please see the "Outline of Medicare Supplement Insurance."

- If **YES**, go to **Section 9**.
- If you answered **NO** to all of the questions in **Section 3**, continue to **Section 4**.

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Answer the health questions in Sections 4-7 ONLY if your acceptance is not guaranteed as defined in Section 3.

4 Tell us about your medical providers.

Provide the following information for all physicians that you have seen within the past 2 years. We may follow up with your physicians for additional information and verification of your health history. If needed, please use an additional sheet of paper and check this box to indicate you are attaching it. ☐

Primary Physician ( ) - Phone #

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

Specialist Name Specialty ( ) - Phone #

Diagnosis/Condition

TEAR HERE

First Name Last Name

5 Answer this health question. If you answer YES or NOT SURE, we may follow up for additional information.

5A. Within the past 2 years, did a medical professional provide treatment or advice to you for any problems with your kidneys other than kidney stones?	☐Yes ☐No ☐Not Sure

6 Answer these health questions. If you answer YES to any question, you are not eligible for coverage. If you answer NOT SURE, we may follow up for additional information.

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6A. Were you hospitalized as an inpatient (not including overnight Outpatient observation) • within the past 90 days or • 3 or more times within the past 2 years?	☐Yes ☐No ☐Not Sure
6B. Are you confined to a bed, receiving home health care, or currently being treated or living in any type of nursing facility other than an assisted living facility?	☐Yes ☐No ☐Not Sure
6C. Within the past 2 years, did you receive IV infusions or injections for Primary Immunodeficiency Syndrome?	☐Yes ☐No ☐Not Sure
6D. Has a medical professional ever told you that you have End-Stage Renal (Kidney) Disease (ESRD) or that you may or will require dialysis?	☐Yes ☐No ☐Not Sure
6E. Within the past 5 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for: • Leukemia, Lymphoma or Multiple Myeloma?	☐Yes ☐No ☐Not Sure
6F. Within the past 3 years, were you diagnosed with, treated, given medical advice, or prescribed medications by a medical professional for: • Cancer (other than Leukemia, Lymphoma, or Multiple Myeloma) • Melanoma or Metastatic Merkel Cell (but not other skin cancers)?	☐Yes ☐No ☐Not Sure
6G. Within the past year, did a medical professional tell you that you may need any of the following that **has NOT been completed**: • Any surgery, biopsy, further evaluation, treatment, or diagnostic testing?	☐Yes ☐No ☐Not Sure
6H. Are you awaiting any diagnostic test results?	☐Yes ☐No ☐Not Sure

TEAR HERE

First Name Last Name

7 **Answer these health questions to determine your rate only if you are age 65 or over.** If you answer YES to any question, your rate will be the Level 2 rate (see "Cover Page – Rates"). If you answer NOT SURE, we may follow up for additional information.

7A. Within the past 5 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?	
• Pulmonary Heart Disease, Heart Failure, Ventricular Tachycardia, or a cardiac defibrillator	☐Yes ☐No ☐Not Sure
• Diabetes, but only if you have Neuropathy, Retinopathy, any kidney problems, proteinuria, or any circulation problems	☐Yes ☐No ☐Not Sure
• Liver Fibrosis or Cirrhosis, Liver Failure or Chronic Kidney Disease (CKD)	☐Yes ☐No ☐Not Sure
• Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)	☐Yes ☐No ☐Not Sure
• Alzheimer's Disease, Dementia, or Parkinson's Disease	☐Yes ☐No ☐Not Sure
• Any condition that resulted in, or will require a bone marrow, stem cell, or organ transplant	☐Yes ☐No ☐Not Sure
7B. Within the past 2 years, did a medical professional tell you that you have or were you diagnosed with, treated, given medical advice, or prescribed medications for any of the following?	
• Artery blockage, or had bypass surgery, stents, or balloon angioplasty	☐Yes ☐No ☐Not Sure
• Heart Attack, Cardiomyopathy, an Enlarged Heart, or Atrial Fibrillation	☐Yes ☐No ☐Not Sure
• Carotid Artery Disease, Stroke, Transient Ischemic Attack (TIA), or Mini-Stroke	☐Yes ☐No ☐Not Sure
• Peripheral Vascular Disease (PVD) or Amputation due to disease	☐Yes ☐No ☐Not Sure
• Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or Cystic Fibrosis	☐Yes ☐No ☐Not Sure
• Any lung or respiratory disorder: - requiring the use of a nebulizer or oxygen, - on 3 or more medications, or - currently using tobacco products	☐Yes ☐No ☐Not Sure
• Hemophilia, Hepatitis (other than A) or Pancreatitis	☐Yes ☐No ☐Not Sure
• Osteoporosis, but only if you received injections or have had a fracture	☐Yes ☐No ☐Not Sure
• Spinal Stenosis, Quadriplegia, Paraplegia, or Hemiplegia	☐Yes ☐No ☐Not Sure
• Psoriatic Arthritis or Rheumatoid Arthritis	☐Yes ☐No ☐Not Sure
• Systemic Lupus Erythematosus (SLE) or Myasthenia Gravis	☐Yes ☐No ☐Not Sure
• Macular Degeneration, but only if you have the Wet form	☐Yes ☐No ☐Not Sure
• Bipolar Disorder or Schizophrenia	☐Yes ☐No ☐Not Sure
• Alcoholism or Drug Abuse	☐Yes ☐No ☐Not Sure
7C. Within the past 2 years, did you receive any of the following: • Skin grafts, or • Blood transfusions, IV infusions or injections (not including vaccinations or B12 injections) for any of the following conditions? • Asthma • Autoimmune disorders • Blood disorders • Cognitive impairment • Connective tissue disorders • Eye disorders • Genetic or Hereditary disorders • Migraine headaches • Osteoarthritis	☐Yes ☐No ☐Not Sure

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TEAR HERE

First Name Last Name

8 Tell us about your tobacco usage. If you answer YES to this question, your rate will be the tobacco rate (see "Cover Page - Rates").

8A. At any time within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product?	☐Yes ☐No

9 Your past and current coverage

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Review the statements.

- You do not need more than one Medicare supplement 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, Medicare cost or Medicare select policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement, Medicare cost or Medicare select 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, Medicare cost or Medicare select 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 you are eligible for, and have enrolled in a Medicare supplement, Medicare cost or Medicare select 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, Medicare cost or Medicare select 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, Medicare cost or Medicare select policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement, Medicare cost or Medicare select 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.
- 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). See the booklet "Wisconsin Guide to Health Insurance for People with Medicare" which you received at the time you were solicited to purchase this insurance.

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PLEASE ANSWER ALL QUESTIONS.
To the best of your knowledge,

Questions about Medicaid	
9A. Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run health care program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) Note to applicant: If you are participating in a "Spend-down Program" and have not met your "Share of Cost", answer NO to this question. **If YES, you must answer Questions 9B and 9C.**	☐Yes ☐No
9B. Will Medicaid pay your premiums for this Medicare supplement policy?	☐Yes ☐No
9C. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	☐Yes ☐No
Questions about Medicare Advantage plans (sometimes called Medicare Part C)	
9D. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO, or PPO)? **If YES, you must answer Questions 9E through 9H.**	☐Yes ☐No