Physicians Mutual®

Application Training

Two Ways to Take an Application + Signature Options:

1. E-app (preferred method) using the Agent Platform (or launch from CGS, Connecture etc.)
    - In-Person: sign via mouse or stylist pen
    - Remote: sign via DocuSign or IVR
2. Paper application
    - Required for underage Med supp apps and apps signed by POA (must be wet)
    - Wet signature or DocuSign (sent once paper application is received)
    - Upload via the secure document upload (except for claims) on the Agent Platform
    - Email Sales Support at Sales.Support@PhysiciansMutual.com

*__DocuSign Code__ is the __LAST 4 DIGITS__ of the __PHONE NUMBER__ provided on the application.

Payment Options

Paper Application:

- ABW: complete ABW form (keep $5/month discount)
- Quarterly, semi-annual, and annual direct bill (keep $5/month discount). Not available via ABW or credit card. Collect check.
- Monthly direct bill (lose $5/month discount). Collect check.

E-App:

- In person: all payment options above are available.
- Virtual: ABW (keep $5/mo. Discount) or monthly credit or debit card (lose $5/month discount).

Mail checks to :

Physicians Mutual
601 Galvin Rd S ATTN: Agency 5th Floor
Bellevue, NE 68005

*If paying by check, application will not issue until received.

Payment Method Discounts

Payment methods that receive the $5/month discount include:

- Monthly ABW
- Quarterly, semi-annual or annual direct bill paid via check or credit card.

*Monthly credit or debit card payments and monthly direct bill by check do not receive the $5/month discount.

Initial and Subsequent Premiums

First premium is always *taken immediately at issue* even if the effective date is future and pays for the first month's premium as a binder.

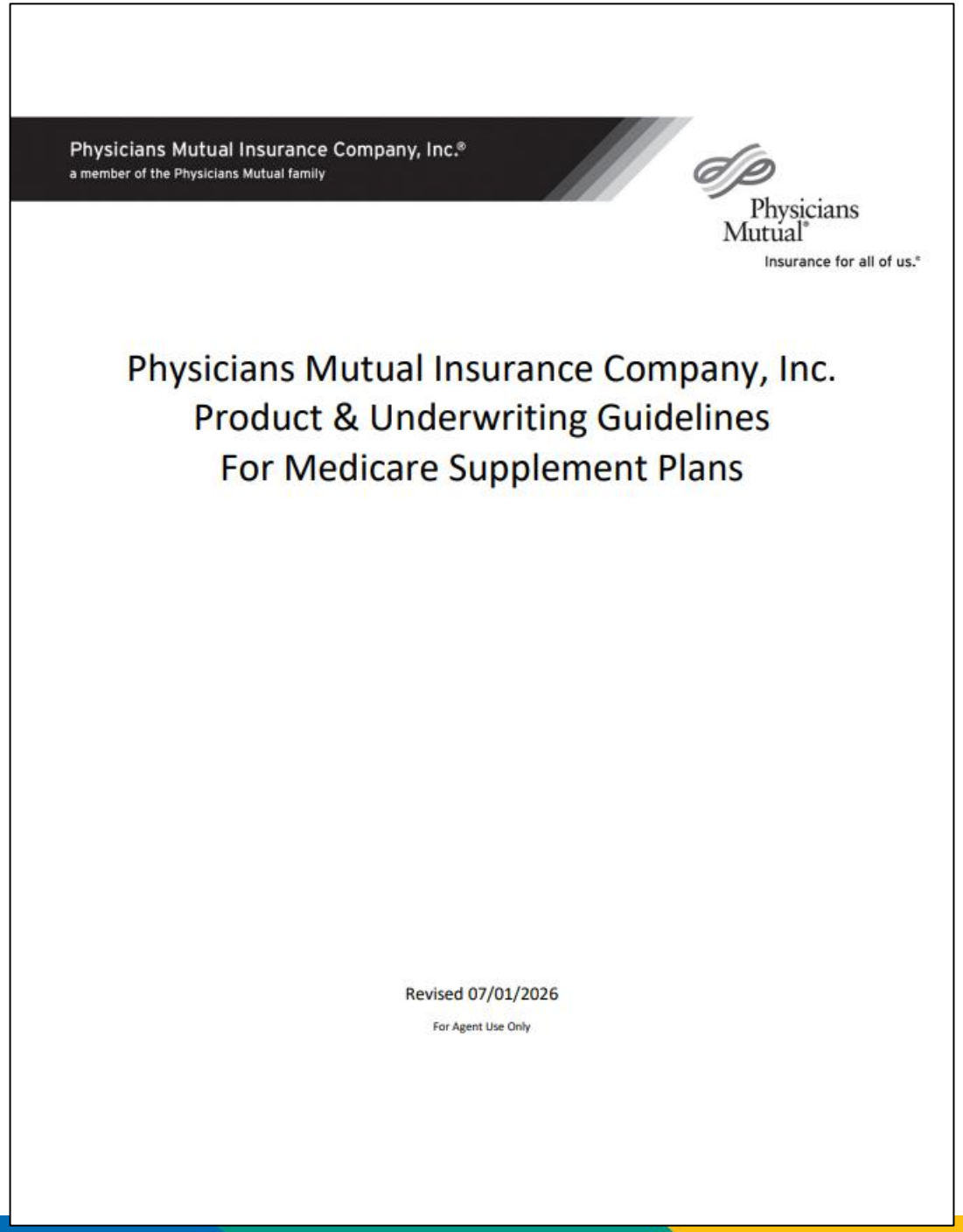
Issued vs. Effective: Policies are issued on the date approved. Policies are effective on the date that coverage becomes active.

Scheduling subsequent premium deductions for ABW:

- Subsequent premium withdrawal date is determined by customer's choice of withdrawal date
- Withdrawal Dates of 1st -10th (for policies that begin on the 1st) of the month (grace period) will be deducted in the month the premium is due.
- Dates 11th-28th will be deducted the month BEFORE the premium is due.
- Dates 29th, 30th, 31st are not permitted.
- Selecting the due date for ABW is recommended (My Account Discussion).
- Examples. Questions?

Application requirements can be found in the **Underwriting Guidelines** on the Agent Platform

Outstanding/pending requirements can be found in the mobile Agent Assistant app or **contact Sales Support.**


Physicians Mutual Insurance Company, Inc.®
a member of the Physicians Mutual family

Physicians Mutual®
Insurance for all of us.®

Physicians Mutual Insurance Company, Inc.
Product & Underwriting Guidelines
For Medicare Supplement Plans

Revised 07/01/2026

For Agent Use Only

Physicians Mutual®

NOTE: It is required to provide your client with the Medicare Supplement Outline of Coverage & Disclosures, as well as the Choosing a Medigap Policy Booklet Available for download from S3.

Disclosures can be sent with a **push of a button** when taking an electronic application and an email address is provided.

Plan G Wellness Plus with Deductible Discount Rider

MEDICARE (PART A) – CONTINUED

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
BLOOD			
First 3 pints	$0	3 pints	$0
Additional Amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness	All but very limited copay/coinsurance for outpatient drugs and inpatient care	Medicare copayment/coinsurance	$0

MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $283 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

**This Plan G with the Plan G Deductible Discount Rider pays the same benefits as Plan G after you have first paid a calendar year deductible ($2,950 in 2026, subject to change annually). Benefits will not begin until out-of-pocket expenses meet the deductible. Out-of-pocket expenses for this deductible include expenses for the Medicare Part B deductible, and expenses that would ordinarily be paid by the policy. This does not include the plan's separate foreign travel emergency deductible. On or after the Deductible Elimination Date as defined on the Policy Schedule, the calendar year deductible is zero.

SERVICES	MEDICARE PAYS	AFTER YOU PAY CALENDAR YEAR DEDUCTIBLE,** PLAN PAYS	IN ADDITION TO CALENDAR YEAR DEDUCTIBLE,** YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment			
First $283 of Medicare approved amounts*	$0	$0	$283 (Unless Part B Deductible has been met)
Remainder of Medicare approved amounts	Generally 80%	Generally 20%	$0
PART B EXCESS CHARGES (Above Medicare approved amounts)	$0	100%	$0

AEP Apps

When?

- AEP applications (for clients coming off an MA plan) can be submitted as early as October 1st for a January 1st effective date

No Coverage Overlap

- Make sure that current MA plan is cancelled
- When replacing an MA plan, proof of current coverage disenrollment is **not required** (unless it is a GI/SEP app).
- However, PMIC will send a letter to your client asking for a disenrollment letter, as a "nice to have" to avoid overlapping coverage.
- Your client will not lose their PMIC plan if they don't provide this.
- However, if the client submits a disenrollment letter that shows that coverage did not end on December 31st, OEP will be used instead of AEP and **the effective date will be moved.**

Medicare Advantage OEP

When?

- January 1-March 31 OR
- Within the first 3 months you get Medicare

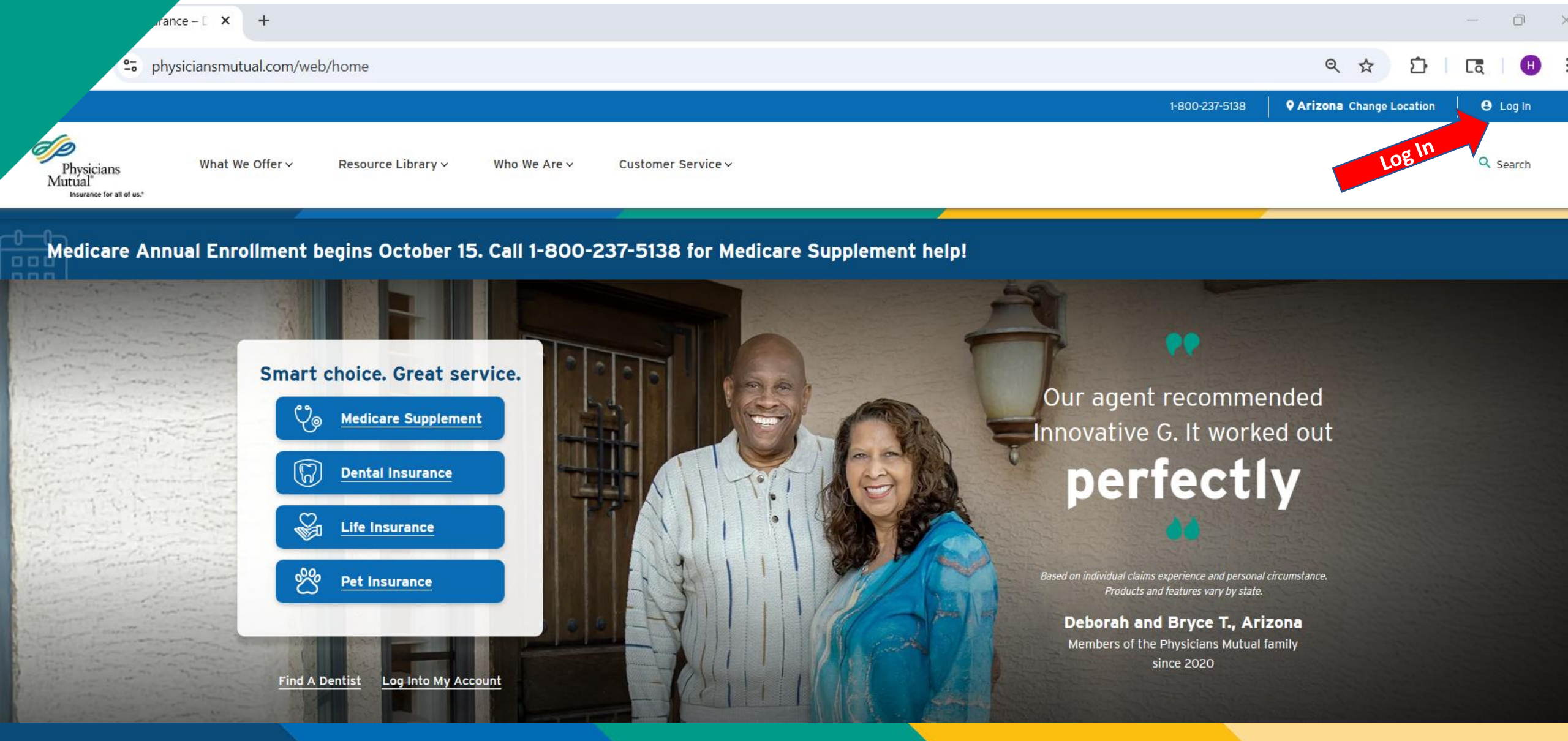
What can you do?

- Switch to another Medicare Advantage Plan with or without drug coverage.
- Drop your Medicare Advantage Plan and go back to Original Medicare.
- Join a Medicare drug plan

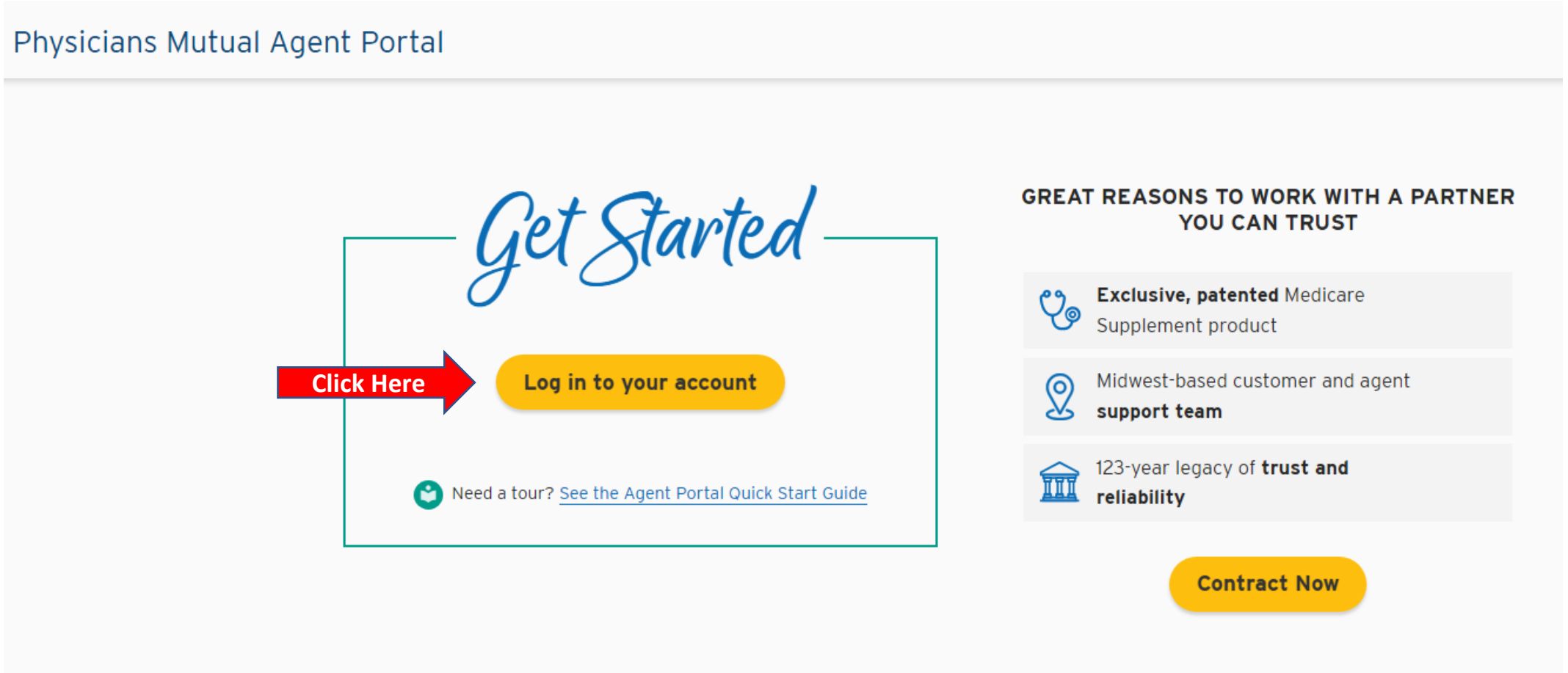
Coverage starts:

- First of the month after the plan gets your request.

Let’s Take a Med supp e-App!



Bookmark: https://portal.physiciansmutual.com/eselfcare/login



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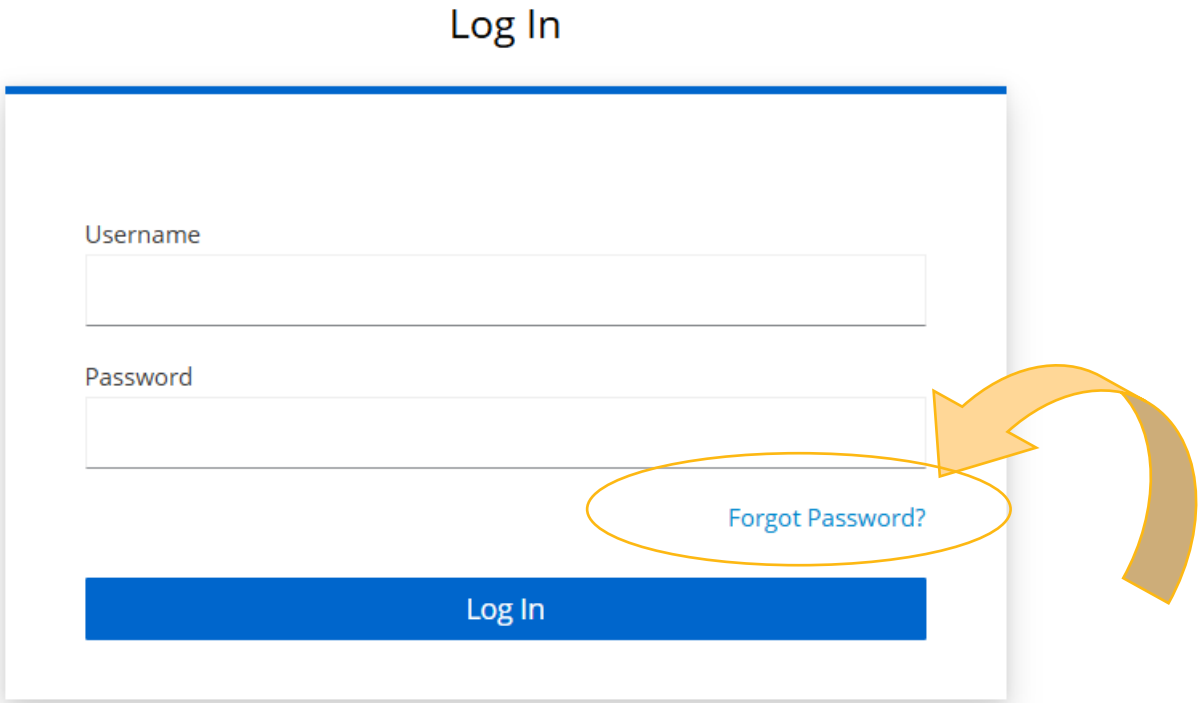

Your Username is your NPN.
The first time you log in click Forgot Password to create a password via email link.

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Physicians Mutual®

Log In

Username

Your NPN

Password

CreateAPassword!#

Show password

Forgot Password?

Click Here

Log In

Physicians Mutual®

Physicians Mutual Agent Portal

Sales Support: 1-877-888-5580

New Innovative Plan G video for your clients

In just minutes, your clients can get a clear overview of Innovative Plan G. It's quick, informative, and perfect for appointments. Help your clients feel confident and in control with this video!

Popular Links

Write App

- Agent Quoting
- Electronic Application
- Marketing & Sales Materials

Physicians Mutual®

*Resident State: Ohio

Select State

Agent Details

+ Add	*NPN	Name	Assigned	*Percentage
	10216739	Holly Frank		100

Enter NPN #

Appointment Type

*Appointment type will determine signature and billing options available within the application.

In-Person | Remote

Select In-Person or Remote

Product Details

Health or Life

*Product Line: HEALTH

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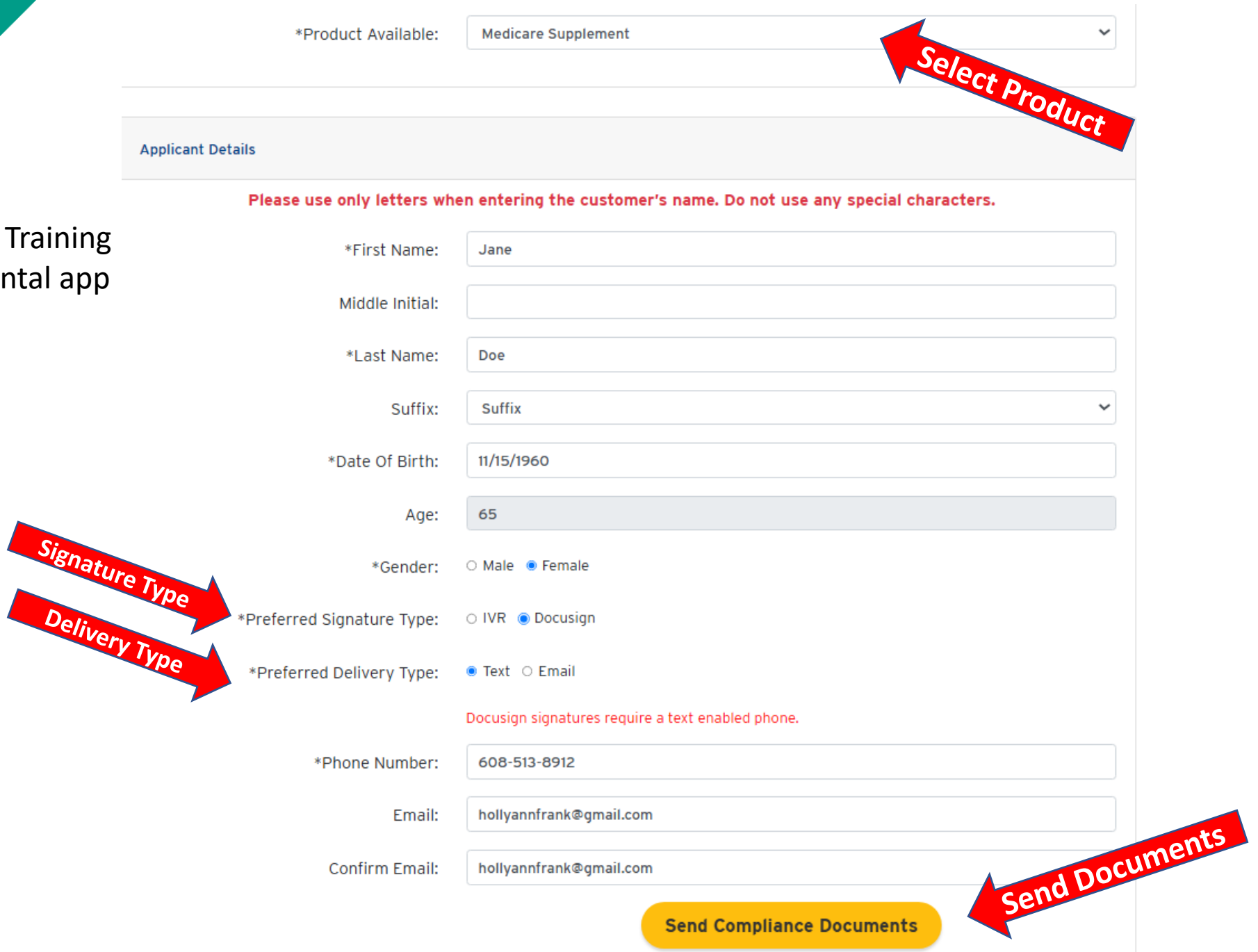
See Dental Training to see a dental app



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Address Details

*Validate Address

Entered Address	Suggested Address
319 Claremont Ct Napervilee, IL 60540	319 CLAREMONT CT NAPERVILLE,IL 60540-4485
Keep	Accept

Click Here

Address Details

*Address Line 1:	319 CLAREMONT CT
Address Line 2:	
*City:	NAPERVILLE
*State:	Illinois
*Zip:	60540-4485

Save Next

Click Here

Physicians Mutual®

Quote for Medicare Supplement Insurance

Zip Code (Required)

60540-4485

Date of Birth (Required)

11/15/1960

Gender (Required)

FEMALE

Planned Start Date for New Coverage (Required)

12 | 01 | 2025

Household Discount 10% (Required)

Click for HH Disc Rules

Yes | No

Payment Method (Required)

Automatic Bank Withdrawal

Credit or Debit Card

First eligible for Medicare prior to January 1, 2020. (Required)

Yes | No

Get Your Quote

Household Discount rules vary by state. See state product summary for more.

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Household Discount
(Qualify if "YES" to either questions)

If you either reside in a household with your spouse, or with another person (but no more than three) that is age 60 or older and has continuously resided with you for the last 12 months, we will provide you a 10% household discount off your Medicare Supplement premium.

If you do not qualify for the household discount when your policy is first issued, you may qualify at a later date if the above qualifications are met and we receive a completed Household Discount Questionnaire that reflects an attestation to the resident information.The discount may be removed if you no longer meet requirements.

H_MSUPD_HD1c

First eligible for Medicare prior to January 1, 2020. (Required)

Yes | No

Click Here

Get Your Quote

Great news! Your rate quote includes money saving household and Automatic Bank Withdrawal discounts!

Plans Available	Premium	Tobacco Premium
Plan A	$150.51	$169.33
Plan G	$178.91	$201.28
Innovative Plan G	$126.54	$142.36
High Deductible G	$63.58	$71.53

Select Plan

Optional Rider

Rider Benefits

Optional Preventive Benefit Plus Rider (Required) — $9.53 — $9.53

Yes | No

Total premium for selected benefits: $136.07 $151.89

Save | Start Application

Click Here

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Physicians Select Insurance Company®

1 Plan Information — 2 Existing Coverage — 3 Review your Application Information — 4 Pa

Medicare Supplement Application

Please provide the information below.

Check Box

☑ I agree that I have provided the Outline of Coverage and limitations.

APPLICATION · Medicare Supplement, Physicians Select Insurance Company, 2600 Dodge Street, Omaha, NE 68131-2671

Plan Information

Plan Selected: Medicare Supplement Innovative Plan G

Your quote: $136.07

Planned start date for new coverage: 12/01/2025

Discount Information

Tobacco Discount: Applied

Household Discount: Applied

Personal Information

First Name (Required)

Jane

Middle Initial (Optional)

Physicians Mutual®

Doe

Suffix (Optional)

Suffix

Date of Birth

11/15/1960

Age

65

Gender

FEMALE

Phone Number (Required)

608-513-8912

Optional

Social Security Number (Optional)

Email

hollyannfrank@gmail.com

Medicare Number (Required)

Unavailable

Unavailable

Enter exactly as shown on your red, white, and blue Medicare Card. If you're not yet enrolled in Medicare or have enrolled but not yet received your Medicare card, you may leave this blank.

No need to wait for Medicare #!

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Legal Address (Residence)

A Post Office Box is not a legal address.

Address Line 1

319 CLAREMONT CT

City

NAPERVILLE

State

Illinois

Zip Code

60540-4485

Is this applicant able to receive mail at their legal address? (Required)

Click Here

Yes

No

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Household Premium Discount

You may qualify for a premium discount based on a YES answer to either of the following questions:

Do you have a household resident (at least one but no more than three) that is age 60 or older, with whom you have continuously resided for the last 12 months? (Required)

Yes No

Do you reside in a household with your spouse*? (Required)

*Spouse includes Registered Domestic Partner, Civil Union Partner, or party to a domestic partnership between two adults, as recognized by state law.

Yes No

If you answered "YES" to either of the questions above, please complete the information below :

Enter Info

Name of household resident/spouse (Required)

John Doe

Address (Required)

same

Date of Birth (Required)

MM DD YYYY

Unknown

Click Here

Cancel Save Continue

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1 Plan Information — 2 Existing Coverage — 3 Review your Application Information — 4 Payment Information — 5 Second Review and Statements

Medicare Supplement Application

Plan Information

Plan Selected: Medicare Supplement Innovative Plan G

Your quote: $136.07

Planned start date for new coverage: 12/01/2025

Discount Information

Tobacco Discount: Applied

Household Discount: Applied

Information About Existing Coverage

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 that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans.

PLEASE ANSWER ALL QUESTIONS.(Some of the information can be found on your Medicare card.)

1. Are you covered under Medicare Part A? (Required)

Yes | **No**

What is your Part A effective date? (Required)

12 | 01 | 2025

2. Are you covered under Medicare Part B? (Required)

Yes | **No**

What is your Part B effective date? (Required)

12 | 01 | 2025

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For questions #5-8, about existing coverage, only one can be answered Yes.

5. Are you covered for medical assistance through the state Medicaid program? (Required)

If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.

Yes **No**

6. Have 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**)? (Required)

Yes **No**

7. Do you have another **Medicare Supplement** policy in force? (Required)

Yes **No**

Have you had another Medicare Supplement policy within the last 180 days?(Required)

Yes **No**

8. Have you had coverage under any **other health insurance** within the past 63 days? (For example: an employer, union, or individual plan.) (Required)

Yes No

a. What company and what kind of policy? (Required)

Company Name (Required)

Dean

Policy (Required)

Employer Plan Union Plan Individual Plan Other

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

Start Date: (Required)

01 01 2025

End Date: (Optional)

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Yes | No

What is your planned date of termination/disenrollment? (Required)

11 | 30 | 2025

Cannot Overlap

Important Statements to be Read by Medicare Supplement 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 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.

(5) 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 suspension.

(6) 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).

(7) Persons aged 65-75 who have an existing Medicare supplement policy shall be eligible commencing on their birthday for an open enrollment period of 45 days to select any of the same issuer's other Medicare supplement policies that offer benefits equal to or lesser than the person's existing coverage. An issuer shall not deny or condition the issuance or effectiveness of coverage or discriminate in pricing based on the person's health status, claims experience, receipt of healthcare, or medication condition, including any preexisting condition.

Click Here

Back | Cancel | Save | Continue

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Physicians Select Insurance Company®

1 Plan Information — 2 Existing Coverage — 3 Review your Application Information — 4

Medicare Supplement Application

Please review the information you submitted and make sure everything is correct.If you find an error, please c

Please read before trying to edit: Edit

Changes to this information will return you to the quote page.

Plan Information

Plan Selected: Medicare Supplement Innovative Plan G

Your quote: $136.07

Planned start date for new coverage: 12/01/2025

Discount Information

Tobacco Discount: Applied

Household Discount: Applied

Existing Coverage Edit

Show Answers

Back | Cancel | Save | Continue

Click Here

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1 Plan Information — 2 Existing Coverage — 3 Review your Application Information — 4 Paym

Medicare Supplement Application

Plan Information

Plan Selected: Medicare Supplement Innovative Plan G

Your quote: $136.07

Planned start date for new coverage: 12/01/2025

Optional Preventive Benefit Plus Rider

Yes **No**

Discount Information

Tobacco Discount: Applied

Household Discount: Applied

Payment Information

You may pay with one of the following methods:

Payment Method (Required)

Automatic Bank Withdrawal

Credit or Debit Card

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Payment Account Information

What type of bank account will you use for your bank withdrawal?

Checking | **Savings**

Routing/Transit Number (Required)

104000016

Bank Account Number (Required)

******

Confirm Account Number (Required)

******

Enter Twice

Requested Withdrawal Day (Optional)

1

Can always add this at a later date.

Third Party Designee

Do you want a third party designee? (Required)

Yes | **No**

I understand I can designate one person other than myself to be notified in the event of an unintentional lapse of my Medicare Supplement insurance policy.
I understand the notice to my designee will not be given until 15 days after my premium is due and unpaid.
I understand I may elect not to designate any person to receive such notice.

☑ I elect not to designate any person to receive any notice.

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Policy Checklist

Existing Insurer (Required):

Dean

Policy Number (Required):

123456

Is there an expiration date? (Required):

Yes | **No**

Hospital Inpatient

First 60 Days (Required):

$1,676.00 | Other Amount | Nothing

61st to 90th day (Required):

$419.00 | Other Amount | Nothing

91st to 150th day (Required):

$838.00 | Other Amount | Nothing

Beyond 150 Days / Lifetime Reserve (Required):

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Post-hospital Skilled Nursing Home Care

Additional 80 days (Required):

$209.50 | Nothing | Other Amount

Beyond 100 days (Required):

Nothing | Other Amount

Medical Expense

Physicians services, etc (Optional):

- [x] 20% of Medicare eligible expenses
- [ ] Part B deductible
- [ ] 100% of Medicare Part B excess charges
- [ ] 80% of Medicare Part B excess charges
- [ ] Nothing
- [ ]

Prescription Drugs

Inpatient prescription drugs (Required):

Nothing | Other Amount | Outpatient Drugs

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Illinois apps only

Prescription Drugs

Inpatient prescription drugs (Required):

Nothing | Other Amount | Outpatient Drugs

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

*The calendar year deductible for 2025 is $2,870, subject to change annually.
If you own a High Deductible Plan G, your benefits will be subject to this deductible every year.
If you own a Plan G with the Deductible Discount Rider,
this deductible will be zero on or after the Deductible Elimination Date as defined on the Policy Schedule.
Also, if you terminate the rider prior to the Deductible Elimination Date, this deductible goes to zero.

Agent's Signature (Required)

Sign Here

Back | Cancel | Save | Continue

Click Here

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1 Plan Information — 2 Existing Coverage — 3 Review your Application Information — 4 Payr

Medicare Supplement Application

Plan Information

Plan Selected: Medicare Supplement Innovative Plan G

Your quote: $136.07

Planned start date for new coverage: 12/01/2025

Discount Information

Tobacco Discount: Applied

Household Discount: Applied

Review Your Personal Information

Please review the information you submitted and make sure everything is correct. If you find an error, please use th

A new application must be started if changes to the Insured or Contact Information are needed.

Primary Insured Information
Jane Doe
Female
11/15/1960 (65 years old)

Contact Information
319 Claremont Ct
Naperville, Illinois 60540-4485
608-513-8912
hollyannfrank@gmail.com

Tobacco Discount ✎ Edit

Have you used any form of tobacco, an electronic cigarette or other nicotine products in the past 12 months?

Household Premium Discount ✎ Edit

Physicians Mutual®

Do you reside in the same household with any other person who owns a Medicare Supplement policy from Physicians Mutual Insurance Company or Physicians Life Insurance Company?
If YES, do you reside with less than four other Medicare-eligible adults?

Optional Benefit Riders ✎ Edit

Preventive Benefit Plus Rider (F019): **YES**

Payment Information ✎ Edit

Total Monthly Premium:	$136.07
Payment Method:	Automatic Bank Withdrawal (Checking)
Routing/Transit Number:	*****0016
Bank Account Number:	**3456
Policy Withdrawal Date:	1
Policy Effective Date:	12/01/2025
Account Holder Name:	Jane Doe
Account Holder Address:	319 Claremont Ct, Naperville, IL 60540-4485

In the future, if you have questions about this authorization, please contact our Policyowner Service Department or Agent.

Third Party Designee ✎ Edit

Do you want a third party designee? **NO**

I understand I can designate one person other than myself to be notified in the event of an unintentional lapse of my Medicare Supplement insurance policy. I understand the notice to my designee will not be given until 15 days after my premium is due and unpaid. I understand I may elect not to designate any person to receive such notice.

I elect not to designate any person to receive any notice.

Applicant Statement and Signature

I certify I have read, or have had read to me, the completed application and I realize any false statement or misinterpretation in the application may result in loss of coverage under the policy.

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge. I understand no coverage is in force until the Company issues a policy showing a Policy Effective Date and the first full premium has been paid.

Agent's Statement and Signature

Thank you. Again, my name is Holly Frank. I am a licensed agent for Physicians Select Insurance Company in the state of Illinois.
I represent and agree I have truly and accurately recorded in this application all information supplied by the applicant. I
also certify that only Company approved sales material was used in connection with this sale.

Review Information. Select Edit or back arrow within the e-App if changes are necessary. Never click the browser back arrow!

I represent and agree that all information stated in this application is complete and correct to the best of my knowledge. I unders

Agent's Statement and Signature

Thank you. Again, my name is Holly Frank. I am a licensed agent for Physicians Select Insurance Company in the state of Illinois
I represent and agree I have truly and accurately recorded in this application all information supplied by the applicant. I also certify that only Company approved sales material was used in connection with this sale.

Does this Medicare Supplement policy replace any insurance presently in force? (Required)

Click Here

Yes | No

Licensed Resident Agent's Name: Holly Frank
Licensed Resident Agent's NPN: 10216739

Licensed Resident Agent's Signature (Required)

Sign Here

Optional

To Be Filled Out By Agent

List any other health insurance policies you have sold the applicant which are still in force: (Optional)

List any other health insurance policies you have sold the applicant in the past five (5) years which are no longer in force: (Optional)

Back | Cancel | Save | Continue

Click Here

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ysicians Select Insurance Company®

1 Plan Information — 2 Existing Coverage — 3 Review your Application Information — 4 Payment Information — 5 Second

Medicare Supplement Application

Physicians Mutual Insurance Company / Physicians Select Insurance Company Acknowledgme

The renewal provision of the policy for which I am applying this date has been explained to me. I understand the policy cannot be cancelled by the Com my premium before the 31-day grace period ends, in which case my coverage stops at the end of the grace period. The Company may change the pren made for all policies of the same form and class held by residents of my state. If the premium is based on attained age, I understand my Renewal Pren after my birthday. I further acknowledge receipt of the Outline of Coverage, the Guide to Health Insurance for People with Medicare, and the Notice to A of Medicare Supplement Insurance or Medicare Advantage and all other forms unique to my state of residence. I understand I may be interviewed by t information.

Agent's Statement

Are you related to any proposed insured by blood or marriage? (Required)

This is Allowed

Yes No

What is your relationship? (Optional)

Physicians Mutual®

Agent's Statement

Are you related to any proposed insured by blood or marriage? (Required)

Yes | No

What is your relationship? (Optional)

Optional

Additional Information Regarding Current or Pending Coverage

Does anyone proposed for coverage have other health or life insurance coverage with Physicians Mutual Insura
Insurance Company currently pending or issued within the last 90 days? If yes, please provide the following inf

Policyowner's Name: Jane Doe

Policy Type(s) (Life, Cancer,etc.) (Optional)

Policy Number(s) (Optional)

Date Issued (If applicable)

MM | DD | YYYY

Back | Cancel | Save | Continue

Click Here

Physicians Mutual®

1 Plan Information — 2 Existing Coverage — 3 Review your Application Information

Medicare Supplement Application

Proof of Medicare Eligibility

Valid proof of Medicare enrollment is required to process this application. Use this form to recor
Medicare Health Insurance card.

Applicant Name: Jane Doe

Medicare Number

NOT PROVIDED

Hospital (Part A) Effective Date

12/01/2025

Medical (Part B) Effective Date

12/01/2025

Are both Medicare Parts A and B coverage active? (Required)

Click Here

Yes No

I (we) certify the above information was taken directly from the applicant's Medicare card.

Agent's Signature (Required)

Sign Here

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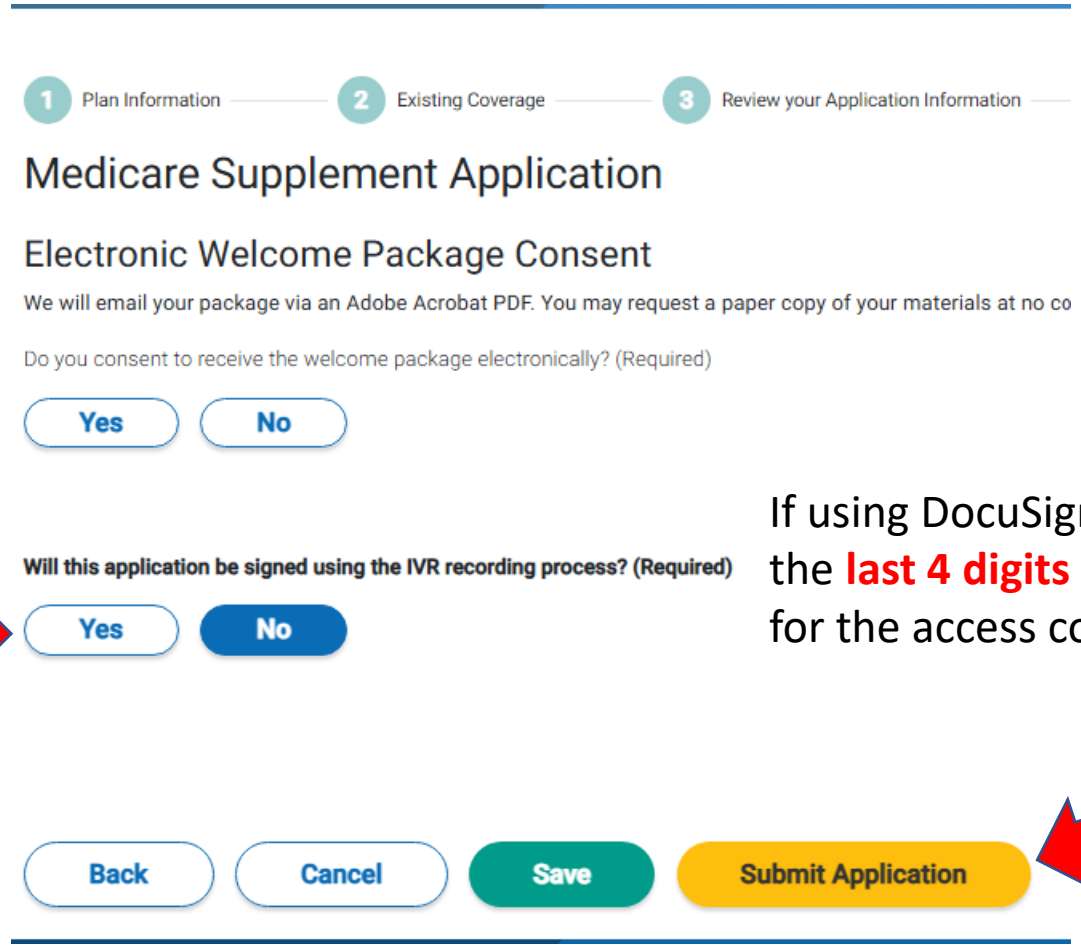

Paperless?

Click yes if customer does not want to sign via DocuSign. IVR (interactive voice recording) involves a 3-way call for voice signature.

If using DocuSign, **remind client** to enter the **last 4 digits of their phone number** for the access code.

Submit

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If the client will sign via IVR, the number and script will appear in the e-app

Capture voice recorded signatures for the following forms. Please call 866-939-8886 to start the IVR process.

Please read the entire script in red below to obtain a valid IVR audio signature:

I will now start recording the audio signature for policy number H730031676. Please verify your first and last name.

☐ Please say 'yes' to confirm that you have read or had read to you the Application, Authorization for Automatic Bank Withdrawal, Acknowledgement, and Third Party Designee.

Application

☐ Please say 'yes' to electronically sign the Application form.

Authorization for Automatic Bank Withdrawal

☐ Please say 'yes' to electronically sign the completed Authorization for Automatic Bank Withdrawal.

Acknowledgement

☐ Please say 'yes' to electronically sign the Acknowledgement.

Third Party

☐ Please say 'yes' to electronically sign the completed Third Party Designee Form.

And that concludes the audio signature. I will end the recording now and submit the application.

End recording here by pressing the '#' key on the phone.

DO NOT FORGET TO SUBMIT THE APPLICATION.

Back | Cancel | Submit Application

After the application is submitted:

- You will receive a confirmation with the client name, policy name, policy number, and premium amount.
- The tobacco rate may appear on your screen (Post 65 apps). If eligible for the non-tobacco discount, it will be applied at issue.
- You'll receive an email once it has issued.
- Check status on the Agent Assistant App

Physicians Mutual®

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Call with questions AFTER the Sale + Application Status

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Questions?

Thank You!