

INSURANCE COMPANY OF NORTH AMERICA

Home Office: Philadelphia, Pennsylvania
Administration: P.O. Box 10856, Clearwater, Florida 33757-8856

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION A. PROPOSED INSURED INFORMATION	
Applicant Name <i>(exactly as it appears on your Medicare card)</i>	
Resident Address	Phone <i>(with area code)</i>
City	State, Zip Code
Mailing Address <i>(if different from Resident Address)</i>	
City	State, Zip Code
Date of Birth	Age <i>(as of effective date)</i>
Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security No
Medicare Number	
Email Address	

SECTION B. PLAN AND PREMIUM INFORMATION	
Plan	Requested Policy Effective Date
Household Premium Discount <input type="checkbox"/> No <input type="checkbox"/> Yes <i>(please complete the Household Discount Form)</i>	
Premium \$	
Premium Collected \$	Initial Bank Draft: \$
Payment Mode: Monthly <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Bank Draft <input type="checkbox"/> <i>(Bank Draft ONLY)</i>	

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS	
1. Are you covered under Medicare Part A? If NO, what is your future Part A effective date? _____ If YES, what is your Part A effective date? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you covered under Medicare Part B? If NO, what is your future Part B effective date? _____ If YES, what is your Part B effective date? _____	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you enrolled in Medicare Part B more than once?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you applying during a guaranteed issue or state special enrollment period? <i>(If YES please provide proof of eligibility).</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>

SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to **SECTION F**.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 3–17, you are not eligible for coverage.

1. Height (Feet and inches): _____ Weight (Pounds): _____
2. Have you used tobacco in any form, including cigarettes, vapes, nicotine gum or patches, cigars, chewing tobacco, pipes, or eCigarettes in the past twelve (12) months? Yes No
3. Are you currently hospitalized or in a nursing home or assisted living facility; or, are you bedridden or confined to a wheelchair, or require the assistance of motorized mobility aid, or have you had any amputation caused by disease? Yes No
4. Are you currently receiving any occupational, speech, or physical therapy, or are you currently receiving any services from a home healthcare agency? Yes No
5. Have you had, been medically diagnosed with, or treated at any time for Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other chronic pulmonary disorders, or any medical condition requiring the use of oxygen? Yes No
6. Have you had, been medically diagnosed with, or treated at any time for Parkinson's Disease, Arthritis that restricts mobility, Osteoporosis with fracture, Systemic Lupus, Myasthenia Gravis, Multiple or Amyotrophic Lateral Sclerosis, Scleroderma, Chronic kidney disease (stage 3-5), Chronic Hepatitis, Cirrhosis of the liver, or renal failure requiring dialysis? Yes No
7. Have you been diagnosed with Alzheimer's Disease, Dementia, Muscular Dystrophy, or any other cognitive disorder? Yes No
8. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes No
9. If you have diabetes or take prescription medication to control your blood sugar, have you been medically diagnosed with or treated for any of the following conditions: peripheral vascular disease, peripheral venous thrombotic disease, peripheral artery disease, kidney failure, kidney disease, stroke, transient ischemic attack (TIA), congestive heart failure, or any heart disorder? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes No
10. If you have diabetes or take prescription medication to control your blood sugar, do you take three (3) or more medications (oral or injections) to control your blood sugar? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes No
11. If you have diabetes or take prescription medication to control your blood sugar, do you take four (4) or more medications to control your high blood pressure? If you do **not** have diabetes or do not take prescription medication to control your blood sugar, this question should be answered "NO." Yes No
12. Have you ever had a medical professional advise you to take more than 50 units of insulin daily or have you ever required more than 50 units of insulin daily for diabetes or to control your blood sugar? Yes No

SECTION D. HEALTH QUESTIONS (continued)

13. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for internal cancer (examples include but are not limited to liver, breast or lung cancer, etc.), malignant melanoma, lymphoma, leukemia, Hodgkin's disease, alcoholism or drug abuse, or have you been advised to have a joint replacement? Yes No
14. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for heart attack, cardiac angioplasty, implantation of a pacemaker, bypass surgery, stent placement or replacement, vascular angioplasty, endarterectomy, stroke or transient ischemic attack (TIA)? Yes No
15. Have you been advised by a physician to have surgery (including cataract or joint replacement surgery), medical tests, infusions, treatment or therapy that has not been performed? Yes No
16. Have you been hospital confined three (3) or more times in the last two (2) years? Yes No
17. Have you had, been medically diagnosed with, or treated at any time for an organ transplant, been advised by a physician to have an organ transplant (excluding cornea transplants) or had a cardiac defibrillator implanted? Yes No

If you answer YES to any of the following health questions 18-21, you may be eligible for coverage.

18. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for angina, heart attack, heart disease, heart valve disease, coronary artery disease, aortic or cardiac aneurysm, cardiomyopathy, carotid artery disease (not including high blood pressure), congestive heart failure, atrial fibrillation, peripheral vascular disease, peripheral venous thrombotic disease, enlarged heart, or other heart rhythm disorder? Yes No
19. Within the past two (2) years have you been treated for degenerative bone disease, rheumatoid arthritis, or spinal stenosis? Yes No
20. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for a mental or nervous disorder requiring treatment by a psychiatrist? Yes No
21. Are you currently receiving, or have you been advised to receive injections in a physician's office? Yes No

(Please explain any yes answers to questions 18 – 21 below)

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes No
 If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)
 Date **Originally** Prescribed
 Date prescription last filled
 Dosage and Frequency
 Diagnosis/Condition

Medication Name (copy off pharmacy label)
 Date **Originally** Prescribed
 Date prescription last filled
 Dosage and Frequency
 Diagnosis/Condition

Medication Name (copy off pharmacy label)
 Date **Originally** Prescribed
 Date prescription last filled
 Dosage and Frequency
 Diagnosis/Condition

Medication Name (copy off pharmacy label)
 Date **Originally** Prescribed
 Date prescription last filled
 Dosage and Frequency
 Diagnosis/Condition

Medication Name (copy off pharmacy label)
 Date **Originally** Prescribed
 Date prescription last filled
 Dosage and Frequency
 Diagnosis/Condition

Medication Name (copy off pharmacy label)
 Date **Originally** Prescribed
 Date prescription last filled
 Dosage and Frequency
 Diagnosis/Condition

SECTION F. REPLACEMENT QUESTIONS

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 include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes No
 (b) Did you enroll in Medicare Part B in the last six months? Yes No
 (c) If YES, indicate your effective date. / /

2. 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, answer (a) – (b) below.
 (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No
 (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes No

3. 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.) Yes No
 If YES, answer (a) – (g) below.

- (a) Name of Company _____
 Plan Type & Policy/Certificate No _____
 Company Telephone Number _____
 Coverage Dates: START DATE / /
 (if you are still covered under this plan, leave end date blank) END DATE / /
 (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No
 If YES, have you received a copy of the replacement notice? Yes No
 (c) Reason for termination/disenrollment? _____
 (d) Planned date of termination/disenrollment? / /
 (e) Was this your first time in this type of Medicare plan? Yes No
 (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes No
 (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes No

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes No
 If YES, answer (a) – (d) below.

- (a) Name of Company _____
 Plan Type & Policy/Certificate No _____
 Company Telephone Number _____
 Issue Date / /
 (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes No
 (c) Indicate termination date. / /
 (d) Have you received a copy of the replacement notice? Yes No

SECTION F. REPLACEMENT QUESTIONS (continued)

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

If YES, answer (a) – (c) below.

(a) Name of Company _____
 Plan Type & Policy/Certificate No _____
 Company Telephone Number _____
 Coverage Dates: START DATE / /
 (if you are still covered under this plan, leave end date blank) END DATE / /
 (b) Reason for termination/disenrollment? _____
 (c) Planned date of termination/disenrollment? / /

This section to be completed only by an agent, if applicable.

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company _____
 Policy/Certificate Number _____
 Description of Benefits _____
 Effective Date of Coverage _____
 Name of Company _____
 Policy/Certificate Number _____
 Description of Benefits _____
 Effective Date of Coverage _____
 Name of Company _____
 Policy/Certificate Number _____
 Description of Benefits _____
 Effective Date of Coverage _____

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

Name of Company _____
 Policy/Certificate Number _____
 Description of Benefits _____
 Effective Date of Coverage _____
 Name of Company _____
 Policy/Certificate Number _____
 Description of Benefits _____
 Effective Date of Coverage _____
 Name of Company _____
 Policy/Certificate Number _____
 Description of Benefits _____
 Effective Date of Coverage _____

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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 reinstated, 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstated, 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance and concerning Medicaid.

ELECTRONIC INSTRUCTIONS

Authorization is requested by Insurance Company of North America to act on electronic instructions from the applicant, and to electronically deliver statements and other documents to the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine, and these procedures have been followed.

(Check One)

- I authorize Insurance Company of North America to act on electronic instructions, and to electronically deliver statements and other documents for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address. I acknowledge that should I desire to revoke this written authorization, I will inform the Company in writing, of such revocation.
- I DO NOT authorize Insurance Company of North America to act on electronic instructions, and to electronically deliver statements and other documents.

Note: I acknowledge that I am responsible for notifying Insurance Company of North America in the event that the email address should change and that I have the option to receive written communication in paper form.

AGENT CERTIFICATION

I, the authorized agent, have on the date of application recorded the information as given to me by the Applicant, and certify that during an interview with the proposed applicant, I have truly and accurately recorded in the application the information supplied by the applicant.

<input type="text"/>			Signed at:
Agent Writing Number	Agent's Signature	Signature Date	State

Secondary Agent (if applicable):

<input type="text"/>		
Agent Writing Number	Printed Name of Agent	Percentage of commissions

Policy Mailing Preference: Mail to Insured Mail to Licensed Agent

AUTHORIZATION AND CERTIFICATION

It is very important that you review your application carefully. Misstatements or omissions could cause an otherwise valid claim to be denied. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider that has provided payment, treatment or services to me or on my behalf within the past 10 years ("my providers") to disclose my entire medical record, prescription history, medications prescribed and any other health information concerning me ("protected health information") to the Company. I also authorize any insurance company or agent from which I have applied for or obtained insurance, and any other entity or person having protected health information about me, to disclose it to the Company. Protected health information includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. Protected health information also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

Further, protected health information includes genetic information and genetic test results, and I specifically authorize my providers to disclose such information and results to the Company, subject to the terms and conditions of this authorization.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct my providers and other entities or persons referred to above to release and disclose my entire medical record without restriction.

I further authorize the disclosure of protected health information by the Company to its affiliates, service providers, reinsurers, agents and representatives.

I understand that this protected health information is to be used or disclosed under this authorization so that the Company may: 1) underwrite my application for insurance, make eligibility, risk rating, and policy issuance determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by sending a written request for revocation to Company at their Medicare Supplement Administrative Office: P.O. Box 10856, Clearwater, Florida 33757-8856. I understand that a revocation is not effective to the extent that any person or entity has already relied on this authorization to disclose or use information about me or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that if any of my protected health information is re-disclosed, it may no longer be protected by federal rules governing privacy and confidentiality of health information.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release my complete medical record, the Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments. I understand that I or my authorized representative am entitled to a copy of this authorization. A photocopy of this authorization will be treated in the same manner as the original.

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.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at:

_____ State

_____ Applicant's Signature

_____ Signature Date