APPENDIX FF. MEDICARE SUPPLEMENT INSURANCE QUESTIONS

[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.

[Please mark Yes or No below with an "X"]

To the best of your knowledge:

(1) (a) Did you turn age 65 in the last 6 months?

Yes_____ No_____

(b) Did you enroll in Medicare Part B in the last 6 months?

Yes_____ No_____

(c) If yes, what is the effective date?_____

(2) Are you covered for medical assistance through the state Medicaid program?

[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.]

Yes_____ No_____

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_____

(3) (a) 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 _/_/_ .

(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_____

(c) Was this your first time in this type of Medicare plan?

Yes_____ No_____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes_____ No_____

(4) (a) Do you have another Medicare supplement policy in force?

Yes_____ No_____

(b) If so, with what company, and what plan do you have [optional ofr Direct Mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes_____ No_____

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

Yes_____ No_____

(a) If so, with what company and what kind of policy?

_____

(b) What are your dates of coverage under the other policy?

START _/_/_ END _/_/_ .

(If you are still covered under the other policy, leave "END" blank.)

[**Source:** Added at 22 Ok Reg 1954, eff 7-14-05]