Application for
Medicare Supplement Insurance

Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate

California

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Application for Medicare Supplement Insurance

- If only one applicant, just complete **applicant A** information.
- Mail application and check in the provided business reply envelope.
- Complete all required sections of the application. Any incomplete or missing information could result in delay or closure of your application.

Section 1a. Applicant A information

Applicant A name *(as appears on Medicare card*)*

Phone

Residential address

Apt/suite number

City | **State** | **Zip**

Mailing address *(if different than residential address)*

Apt/suite number

City | **State** | **Zip**

E-mail

Social Security Number

Birth date *(mm/dd/yyyy)* | **Age** | ☐ **Male** ☐ **Female** | **Height** *(feet and inches)* | **Weight** *(pounds)*

Are you a legal resident of the United States? ☐ Yes ☐ No

Medicare card number* | **Effective date: Medicare Part A** | **Medicare Part B**

*Please provide complete Medicare number and a copy of card if possible.
If applicant has not received a Medicare card yet, leave blank.

Section 1b. Applicant B information

Applicant B name *(as appears on Medicare card*)*

Phone

Residential address

Apt/suite number

City | **State** | **Zip**

Mailing address *(if different than residential address)*

Apt/suite number

City | **State** | **Zip**

E-mail

Social Security Number

Birth date *(mm/dd/yyyy)* | **Age** | ☐ **Male** ☐ **Female** | **Height** *(feet and inches)* | **Weight** *(pounds)*

Are you a legal resident of the United States? ☐ Yes ☐ No

Medicare card number* | **Effective date: Medicare Part A** | **Medicare Part B**

Section 2a. Household premium discount information

Household premium discount eligibility information

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

(1) Do you currently live with your spouse, including validly recognized civil union and domestic partners, or do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months?

☐ Yes ☐ No

(2) If you answered "Yes" to question 1 above, please fill out the following information about the household resident, unless both applicants are applying for coverage on this application.

Name

.

Upon verification of eligibility and approval of your application, you will qualify for the discount.

Payment modes

You have a choice among several payment options or modes for paying your premium: annual, semi-annual, quarterly and monthly electronic funds transfer (EFT). Each payment mode, other than annual and monthly electronic funds transfer, results in higher total yearly premium costs. Reasons for higher costs include added collection and administrative costs, time value of money considerations and lapse rates. The annual and monthly electronic funds transfer modes have the same and lowest total yearly premium costs. As a result, there is a time value of money advantage to you for paying monthly versus annually. However, there may be other advantages to you for choosing an annual payment based on your preferences. Your agent can explain the differences in modes and help you decide which is best for you. You may change your payment mode, among the modes available, during the life of your policy. Only one month's premium will be due at the time of application.

Mail policy(ies) to: ☐ Applicant(s) ☐ Agent

Section 2b. Plan and premium information - applicant A

Applicant A Plan selected
•

Requested Medicare Supplement effective date *(mm/dd/yyyy)*
•

Modal premium
$

Modal premium with discount
$

Total initial premium collected/draft
$

Initial premium
☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

Subsequent draft date*
•

Payment mode
☐ Monthly EFT

Payment method
☐ Check ☐ EFT ☐ List bill Billing file identifier:

If applying for household discount, provide the discounted and non-discounted premium amounts.

*Draft date cannot be on the 29th, 30th or 31st of the month. Requesting to have a draft date more than 15 days greater than the policy's paid to date will draft a month in advance.

Section 2b. Plan and premium information - applicant B

Applicant B Plan selected
•

Requested Medicare Supplement effective date *(mm/dd/yyyy)*
•

Modal premium
$

Modal premium with discount
$

Total initial premium collected/draft
$

Initial premium
☐ Draft initial premium upon policy approval ☐ Draft initial premium on policy effective date

Subsequent draft date*
•

Payment mode
☐ Monthly EFT

Payment method
☐ Check ☐ EFT ☐ List bill Billing file identifier:

Section 3. Eligibility questions

To the best of your knowledge:	**Applicant: A**	**B**
1. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
i. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
ii. If yes, what is the effective date? *(mm/dd/yyyy)*		

A — **Applicant A** effective date
•

B — **Applicant B** effective date
•

iii. If you are under age 65, have you been diagnosed with, or treated for End Stage Renal Disease (ESRD)?	☐ Yes ☐ No	☐ Yes ☐ No

Section 3. Eligibility questions *continued*

NOTE: If you are participating in a "Spend-Down Program" and have not met your "share of cost," please **answer no** to question 2.

	Applicant: A	B
2. Are you covered for medical assistance through the state Medi-Cal program?	☐ Yes ☐ No	☐ Yes ☐ No
i. If yes, will Medi-Cal pay your premiums for this Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
ii. Do you receive any benefits from Medi-Cal other than payments toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No

3. 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 date" blank.

A **Applicant A** start date

•

End date

•

B **Applicant B** start date

•

End date

•

	A	B
i. 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	☐ Yes ☐ No
ii. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
iii. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No

	A	B
4. Do you have another Medicare Supplement policy in force?	☐ Yes ☐ No	☐ Yes ☐ No

A **i.** If so for **applicant A**, with what company, and what plan do you have?

Company • Plan •

B If so for **applicant B**, with what company, and what plan do you have?

Company • Plan •

	A	B
ii. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
iii. Are you replacing an Accendo Insurance Company Medicare Supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No

If yes, list policy number:

A **Applicant A**

•

B **Applicant B**

•

Section 3. Eligibility questions *continued*

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.

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

Applicant:

A	B
☐ Yes ☐ No	☐ Yes ☐ No

A

i. If so for **applicant A**, with what company, and what plan do you have?

Company ______________________ Plan ______________________

ii. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.)

Applicant A start date ______________________ End date ______________________

B

i. If so for **applicant B**, with what company, and what plan do you have?

Company ______________________ Plan ______________________

ii. What are your start and end dates of coverage under the other policy? (If you are still covered under the other policy, leave "End date" blank.)

Applicant B start date ______________________ End date ______________________

For agent use only

Check if application is for:

Applicant A	☐ Open Enrollment	☐ Guaranteed Issue	☐ Underwritten
Applicant B	☐ Open Enrollment	☐ Guaranteed Issue	☐ Underwritten

Section 4. Open Enrollment and Guaranteed Issue

Open Enrollment You are eligible for Open Enrollment if you meet one of the following requirements

A. You apply for a Medicare Supplement Plan insurance policy prior to or during the six- month period beginning with the first day of the month in which you are enrolled for benefits under Medicare Part B and:

(i) You are at least age 65, or

(ii) You are less than age 65 and eligible for Medicare on account of total disability (other than End Stage Renal Disease). If you are notified retroactively of your eligibility for Medicare, you are eligible for the six month period following notice of eligibility.

B. You are enrolled in Medicare Part B and you apply for a Medicare Supplement Policy within six months of one of the following events:

(i) You are enrolled in an employer sponsored health plan (including an employer sponsored retiree health plan, COBRA and Cal-COBRA) and

- the plan terminates, or
- you are enrolled under the plan as a spouse and are losing coverage under the plan due to death or divorce from your spouse, or

(ii) You are a military retiree or the spouse or dependent of a military retiree and you are losing access to health care services as the result of a military base closure, the base no longer offers services or you relocate, or

(iii) You are covered under a Medicare supplement policy and coverage terminated because you established residency in a location not served by the issuer of the Medicare supplement policy for which you are enrolled, or

(iv) Due to an increase in your income or assets, you are no longer eligible for Medi-Cal benefits, or you are only eligible for Medi-Cal benefits with a share of cost and you certify at the time of application that you have not met the share of cost.

(v) If you are enrolled in a Medicare Advantage plan and that coverage is terminated by the Medicare Advantage plan, you are entitled to an additional 60-day open enrollment period to be added on to and run consecutively after any open enrollment period authorized by federal law or regulation.

C. If you are enrolled in a Medicare supplement policy, you may change your plan or insurer during an annual open enrollment period of 60 days beginning on your birthday. Your purchase is limited to any Medicare supplement policy that offers benefits equal to or lesser than those provided by the previous coverage. You must submit evidence that you have Medicare Parts A and B with your Application.

Guaranteed Issue You are eligible for Guaranteed Issue for a Medicare Supplement Plan policy if you apply for the policy in the Guaranteed Issue Time Periods described below and you meet one of the following conditions:

1. You are enrolled in an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and

- the plan terminates or ceases to provide such supplemental health benefits to you; or
- the employer no longer provides you with insurance that covers all of the payment for the 20% coinsurance.

2. You are enrolled with a Medicare Advantage organization under a Medicare Advantage Plan (the "Plan") under Medicare Part C or under a Program of All-Inclusive Care for the Elderly (PACE) and any of the following apply:

- The certification of the organization or plan under this part has been terminated; or
- The organization has terminated or otherwise discontinued providing the Plan in the area in which you reside; or
- You are no longer eligible to elect the Plan because:

(i) of a change in your place of residence or other change in circumstances specified by the Secretary of the Department of Health and Human Services (the "Secretary"), excluding those circumstances where you were disenrolled from the Plan for any of the reasons described in Section 1851 (g)(3)(B) of the federal Social Security Act (e.g., where you have not paid premiums on a timely basis, or you have engaged in disruptive behavior as specified in standards under Section 1856); or

(ii) the Plan is terminated for all enrollees residing within a particular residential service area.

- You are enrolled in a Medicare Advantage Plan and that plan reduces benefits, increases the amount of cost sharing or premium or discontinues for other than good cause relating to quality of care, its relationship or contract under the plan with a provider who is currently furnishing services to you. Under this subparagraph, you may be eligible for a Medicare supplement policy issued by the same issuer through which you were enrolled at the time the reduction, increase or discontinuance occurred or one issued by a subsidiary of the parent company of that issuer or by a network that contracts with the parent company of that issuer. If no Medicare supplement contract is available to you from the same issuer, a subsidiary of the parent company of that issuer or a network that contracts with the parent company of the issuer, you may be eligible for a Medicare supplement policy if the Medicare Advantage plan in which you are enrolled does any of the following:

(i) increases the premium by 15 percent or more;

(ii) increases physician, hospital or drug copayments by 15 percent or more;

(iii) reduces any benefits under the plan; or

(iv) discontinues, for other than good cause relating to quality of care, it's relationship or contract under the plan

Section 4. Open Enrollment and Guaranteed Issue *continued*

with a provider who is currently furnishing services to the individual, However, enrollment shall be permitted only during the annual election period for a Medicare Advantage plan, except where the Medicare Advantage plan has discontinued its relationship with a provider currently providing services to you.

- You demonstrate, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the Plan substantially violated a material provision of the organization's contract with the Centers for Medicare and Medicaid Services in relation to you, including the failure to provide you, on a timely basis, with medically necessary care for which benefits are available under the Plan, or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization or agent or other entity acting on the organization's behalf, materially misrepresented the Plan's provisions in marketing the Plan to you; or

- You meet such other exceptional conditions as the Secretary may provide.

3. You are enrolled with:

- An eligible organization under a contract under Section 1876 (Medicare cost); a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; an organization under agreement under section 1833(a)(1)(A) (health care prepayment plan); or an organization under a Medicare SELECT policy; and
- Your enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Guaranteed Issue situation #2 above.

4. You are enrolled in a Medicare supplement policy and the enrollment ceases because:

- Of the insolvency of the issuer or bankruptcy of the non-issuer organization; or
- Of other involuntary termination of coverage or enrollment under the policy; or
- The issuer of the policy substantially violated a material provision of the policy; or
- The issuer or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you.

5. You were enrolled under a Medicare supplement policy and you terminate enrollment and subsequently enroll, for the first time, with

(1) any Medicare Advantage organization under a Medicare Advantage Plan under Medicare Part C;

(2) any eligible organization under a contract under Section 1876 (Medicare cost);

(3) any similar organization operating under demonstration project authority;

(4) any PACE program under Section 1894 of the Social Security Act;

(5) any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan); or (6) a Medicare SELECT policy, and enrollment under this section is terminated by you during any period within the first 12 months of such subsequent enrollment (during which you are permitted to terminate such subsequent enrollment under Section 1851(e) of the federal Social Security Act).

6. You, upon first becoming enrolled for benefits under Medicare Part A at age sixty-five or older, enroll in a Medicare Advantage Plan under Medicare Part C, or in a PACE program under Section 1894 of the Social Security Act, and disenroll from the plan no later than 12 months after the effective date of enrollment.

7. You enroll in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, were enrolled under a Medicare supplement policy that covers outpatient prescription drugs and you terminate enrollment in the Medicare supplement policy and submit evidence of enrollment in Medicare Part D along with the application for a policy.

Guaranteed Issue Time Periods

- In the case of an individual described in situation #1, the guaranteed issue period begins on the later of: (i) the date you receive a notice of termination or cessation of all supplemental health benefits (or, if a notice is not received, notice that a claim has been denied because of such a termination or cessation); or (ii) the date that the applicable coverage terminates or ceases; and ends sixty-three (63) days after the date of the applicable notice;
- In the case of an individual described in situations #2, #3, #5 or #6 whose enrollment terminated involuntarily, the guaranteed issue period begins on the date that you receive a notice of termination and ends sixty-three (63) days after the date the applicable coverage is terminated;
- In the case of an individual described in situation #4 (insolvency of the issuer or bankruptcy of the non-issuer organization), the guaranteed issue period begins on the earlier of: (i) the date that you receive a notice of termination, a notice of the issuer's bankruptcy or insolvency, or other such similar notice if any, and (ii) the date that the applicable coverage is terminated, and ends on the date that is sixty- three (63) days after the date the coverage is terminated;
- In the case of an individual described in situations #2, #4 (issuer or the policy substantially violated a material provision of the policy), #4 (the issuer or an agent or other entity acting on the issuer's behalf, materially

Section 4. Open Enrollment and Guaranteed Issue *continued*

misrepresented the policy's provisions in marketing the policy to you), #5 or #6 who disenrolls voluntarily, the guaranteed issue period begins on the date that is sixty (60) days before the effective date of the disenrollment and ends on the date that is sixty-three (63) days after the effective date;

- In the case of an individual described in situation #7, the guaranteed issue period begins on the date you receive notice from the Medicare supplement issuer during the sixty (60) day period immediately preceding the Part D enrollment period and ends on the date that is sixty-three (63) days after the effective date of the individual's coverage under Medicare Part D;
- In the case of an individual described in this Guaranteed Issue Guide but not described in the preceding situations, the guaranteed issue period begins on the effective date of disenrollment and ends on the date that is sixty-three (63) days after the effective date. Extended Medicare Supplement Access for Interrupted Trial Periods
- In the case of an individual described in situation #5 whose enrollment with an organization or provider described in item (1) is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, the subsequent enrollment shall be deemed to be an initial enrollment;
- In the case of an individual described in situation #6, whose enrollment with a plan or in a program described in situation #6 is involuntarily terminated within the first twelve (12) months of enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, the subsequent enrollment shall be deemed to be an initial enrollment; and For the purposes of situations #5 and #6, no enrollment of an individual with an organization or provider described in #5 (1 through 6), or with a plan or in a program described in #6, may be deemed to be an initial enrollment under this paragraph after the two-year period beginning on the date on which you first enrolled with such an organization, provider, plan or program

Section 5. Health questions

Answer these questions **only if you're applying for underwritten coverage**. Do not answer these questions for an **Open Enrollment** or **Guaranteed Issue** application. (Refer to Section 4 to see if you qualify for Open Enrollment or Guaranteed Issue.) If any health questions are answered "yes" in section 5, except question 12, the applicant(s) will not qualify for this insurance with us.

Question	Applicant: A	Applicant: B
1. Are you dependent on a wheelchair or any motorized mobility device?	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
2. Do any of the following apply to you? Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. congestive heart failure, unoperated aneurysm, defibrillator	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
B. leukemia, lymphoma, multiple myeloma, cirrhosis	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia multiple sclerosis, muscular dystrophy, cerebral palsy	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
F. Have you ever been diagnosed by a member of the medical profession with AIDS Related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS), or have you taken a test for Human Immunodeficiency Virus (AIDS virus) for purposes of obtaining insurance, and had a positive result?	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
*California Law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.		
4. Have you been medically diagnosed or treated by a member of the medical profession for diabetes?		
A. that requires use of insulin	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
C. with history of heart attack or stroke (at any time)	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. alcoholism, drug abuse	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
C. internal cancer, melanoma, Hodgkin's Disease	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
D. hepatitis, disorder of the pancreas	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure

Section 5. Health questions *continued*

	Applicant: A	Applicant: B
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?		
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
B. myasthenia gravis, systemic lupus or connective tissue disorder	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
E. any lung or respiratory disorder and currently use tobacco products	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or surgery that has not been performed or do you have pending test results?	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
9. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
10. Within the past 12 months, do any of the following apply to you?		
A. had a pacemaker implanted	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
D. had a seizure	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
11. Was your last blood pressure reading higher than 175 systolic or higher than 100 diastolic?	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
Systolic is the upper number and diastolic is the bottom number of a blood pressure reading.		
12. Have you used any form of tobacco in the past 12 months? (Including vaping and e-cigarettes)	☐ Y ☐ N ☐ Unsure	☐ Y ☐ N ☐ Unsure
Answering "yes" to question 12 will not disqualify you for this insurance.		

Section 6. Health history - applicant A

If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section**.
If you are unsure or cannot recall, please include this in your response.

Applicant A

Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide diagnosis:

Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide diagnosis:

List the name of any medications you are taking and diagnosis, if known.

Use an additional sheet of paper if needed for explanation.

Section 6. Health history - applicant B

Applicant B

Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide diagnosis:

Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide diagnosis:

List the name of any medications you are taking and the diagnosis, if known.

Section 7. Physician information - applicant A

If this is an **Open Enrollment** or **Guaranteed Issue** application, **do not answer questions in this section**.

Applicant A primary physician | **Phone**

Physician's office name

City | **State**

Specialist seen in the past 24 months | **Specialty**

Reason for seeing *(diagnosis)*

Specialist seen in the past 24 months | **Specialty**

Reason for seeing *(diagnosis)*

Specialist seen in the past 24 months | **Specialty**

Reason for seeing *(diagnosis)*

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

Section 7. Physician information - applicant B

Applicant B primary physician | **Phone**

Physician's office name

City | **State**

Specialist seen in the past 24 months | **Specialty**

Reason for seeing *(diagnosis)*

Specialist seen in the past 24 months | **Specialty**

Reason for seeing *(diagnosis)*

Specialist seen in the past 24 months | **Specialty**

Reason for seeing *(diagnosis)*

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

Section 8. Important statements

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 are available in this state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the Medi-Cal program, including benefits as a Qualified Medicare beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California department's toll-free telephone number 1-800-927-HELP, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the state of California.
7. A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet Web site (www.insurance.ca.gov).

Section 9. Producer compensation

When you purchase insurance from us, we pay compensation to the licensed agent. Intermediaries through whom the licensed agent works may also receive compensation.

The agent or intermediary represents us by simply taking your insurance application, collecting your initial premiums and delivering your policy.

Agent compensation may vary depending on the type of insurance plan you purchase or the specific options included with your policy. The agent can receive compensation by:

- Commissions when a policy is purchased or renewed
- Fees for marketing and administrative services
- Educational opportunities

Some agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses. We may also offer incentive trips or prizes associated with sales contests based on sales criteria. Types of sales criteria include overall sales volume of an agent or intermediary with our companies or percentage of completed sales.

Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

Section 10. Applicant(s) agreement

This agreement is to acknowledge that I am applying for an insurance policy from Accendo Insurance Company that will be issued based on my answers to the questions on this application. I have read, or had read to me, and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and correctly documented. I understand that I will receive a copy of the signed application. I acknowledge that I have received an outline of coverage for the policy that I applied for, along with a copy of Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare.

I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I understand and agree that this application and any policy issued will be the entire contract of insurance. The Company will not be bound by any statements, promises, or information made or given by any agent or other person at any time unless it is in writing, submitted to the Company's administrative office, and made a part of the contract of insurance. An Officer of the Company is the only one who can make, modify or discharge contracts or waive any of the Company's rights or requirements; and any modifications must be documented in writing.

I also understand that I do not have coverage until this application is approved, the first premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I am accepting the terms and conditions of the EFT authorization attached to this application.

I understand that if any answers on this application are incorrect, incomplete or untrue, Accendo Insurance Company has the right to adjust my premium or cancel this policy.

Applicant A signature **Date signed**

X .

Applicant B signature **Date signed**

X .

For your protection California law requires the following to appear on this form :
Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Section 11. Account information - applicant A

Complete this section **if you are requesting electronic funds transfer** (EFT) for premium payment.
Include a voided check with the application.

Applicant A name

Account owner name *(if different than proposed insured's)*

Account owner relationship to proposed insured

- ☐ Business owned by proposed insured
- ☐ Living trust
- ☐ Employer
- ☐ Power of Attorney
- ☐ Conservator/guardian
- ☐ Family member; please specify:

Financial institution name

Account type

☐ Checking ☐ Savings

Routing number

Account number

Section 11. Account information - applicant B

Applicant B name

Account owner name *(if different than proposed insured's)*

Account owner relationship to proposed insured

- ☐ Business owned by proposed insured
- ☐ Living trust
- ☐ Employer
- ☐ Power of Attorney
- ☐ Conservator/guardian
- ☐ Family member; please specify:

Financial institution name

Account type

☐ Checking ☐ Savings

Routing number

Account number

Section 12. Electronic funds transfer (EFT) authorization

I understand and accept these terms and conditions:

- We are authorized to withdraw funds periodically from your account to pay insurance premiums for the insured.
- If your financial institution does not honor an EFT request, we will NOT consider your premium paid.
- If your financial institution does not honor an EFT request, we may make a second attempt within five business days.
- We have the right to end EFT payments at any time and bill you directly either quarterly or less frequently for premiums due.
- Information as to each EFT charge will be provided by entry on your account statement or by any other means provided by your financial institution. You will not receive premium notices from us.
- If you want to cancel or change this authorization, you must contact us at least three business days before a scheduled withdrawal.
- Any refund of unearned premium will be made to the policy owner or the policy owner's estate.

Signature only required if the account owner is different than the proposed insured.

Account owner signature - applicant A

X

Date signed

Account owner signature - applicant B

X

Date signed

Section 13. Agent information

Please list any other medical or health insurance policies sold to **applicant A.**

1) List policies sold which are still in force

•

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

•

Please list any other medical or health insurance policies sold to **applicant B.**

1) List policies sold which are still in force

•

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

•

I certify that:

1. I have truly and accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and A Guide to Health Insurance for People with Medicare to applicant(s) prior to completing the application.
4. I understand that if I, as an agent, state any material fact that I know to be false, I am subject to a civil penalty of up to ten thousand dollars ($10,000).

All information must be completed. The writing number reflects where commissions will be paid.

Agent name *(printed)*

• ☐

Agent signature

X

Writing number *(agent or company)*

•

State license ID number *(for FL only)*

•

Phone

•

Email

•

Section 14. Agent request to split commissions

If this application results in an issued policy through Accendo Insurance Company (ACC), the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with ACC in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains in force.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions are based on their respective ACC commission schedule.

Writing agent name *(printed)*

•

Percentage

• %

Writing agent signature

X

Secondary agent

•

Writing number

•

Percentage

• %

This section must be completed with this application in order to split commissions. By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Applicant receipt

Thank you for choosing Accendo Insurance Company

part of the CVS Health® family of companies and Aetna affiliate

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Accendo Insurance Company.
- **DO NOT** make any check payable to the agent and **DO NOT** leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Applicant A name *(printed)*

Date of application

Initial payment collected *(if applicable)*
$

Payment type
☐ Check ☐ Money order

EFT draft amount
$

EFT draft date

Applicant B name *(printed)*

Date of application

Initial payment collected *(if applicable)*
$

Payment type
☐ Check ☐ Money order

EFT draft amount
$

EFT draft date

This acknowledges receipt of your application for an Accendo Insurance Company Medicare Supplement insurance policy.

Agent name *(printed)*

Agent signature
X

Phone

Email

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