MEDICARE SUPPLEMENT

Underwriting Guidelines

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Contacts

Addresses for Mailing New Business and Delivery Receipts
When mailing or shipping your new business applications, be sure to use the preaddressed envelopes.

Brokerage Mailing Information

Mailing Address
WoodmenLife
PO Box 2944
Omaha, NE 68103-2944

Overnight/Express Address
WoodmenLife
3316 Farnam St.
Omaha, NE 68175

Fax Number for New Business
Automated Bank Account Withdrawal Applications 1-866-422-9139

Electronic Application
Electronic applications can be accessed through one of the following:

SPA: www.mutualofomaha.com/broker

WoodmenLife: www.insurancetoolsportal.com

Certificate Issue Guidelines

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare supplement insurance certificates for Woodmen of the World Life Insurance Society, hereafter referred to as the "Company". Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluations of each risk. To ensure we accomplish this goal, the producer or applicant will be contacted directly by underwriting if there are any problems with an application.

The following certificate issue guidelines apply:

- Applicants must have or plan to obtain Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance)
- Applicants must be covered under Medicare Part A and Part B in Michigan and Texas
- Certificate issue is state specific
- The applicant's state of residence controls the application, forms, premium and certificate issue
- If an applicant has more than one residence, the state where taxes are filed should be considered as the state of residence
- Please refer to Sales Professional Access for required forms specific to your state

Newly Eligible Clients and MACRA

As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), new rules apply to individuals who are newly eligible for Medicare on and after Jan. 1, 2020.

"Newly Eligible" Medicare Beneficiary Defined by MACRA — In this subsection, the term 'newly eligible Medicare beneficiary' means an individual who is neither of the following: "(A) An individual who has attained age 65 before Jan. 1, 2020. "(B) An individual who was entitled to benefits under part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before Jan. 1, 2020.

Open Enrollment
To be eligible for Open Enrollment, an applicant must be at least 64½ years of age (in most states) and be within six months of his/her enrollment in Medicare Part B. Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month Open Enrollment period upon reaching age 65.

If an individual is entitled to a OE/GI situation we must honor the processing of that application in that method. For compliance purposes we are unable to medically underwrite an individual who is eligible for an Open Enrollment or Guarantee Issue right outlined by CMS.

Additional Open Enrollment Periods
Residents in the following states have additional Open Enrollment periods:

Illinois
Annual Open Enrollment lasting 45 days, beginning on an individual's birthday, during which time a person may replace the Company's Medicare supplement certificate with the Company's certificate equal to or lesser benefits. An individual must be between the ages of 65 through 75 to be eligible. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from application. This option in not available on closed blocks.

Louisiana
Annual Open Enrollment lasting 63 days, beginning on an individual's birthday, during which time a person may replace any Company's Medicare supplement certificate with the Company's certificate of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday or beyond 60 days from the application date. This option in not available on closed blocks.

Please note some states may have additional Open Enrollment rights under state law.

States with Under Age 65 Requirements
The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) defines "newly eligible" as anyone who: (a) attains age 65 on or after Jan. 1, 2020, or (b) who first becomes eligible for Medicare benefits due to age, disability or end-stage renal disease on or after Jan. 1, 2020.

Plans C and F (including High Deductible F) are not available to "newly eligible" Medicare beneficiaries. As states enact or update their specific under age 65 requirements in relation to MACRA, this section will be updated accordingly.

State	Plans Available	Open Enrollment Requirements
GA, IL, LA, MS	All plans***	Open Enrollment if applied for within six months of Part B enrollment
TX	A	Open Enrollment if applied for within six months of Part B enrollment

Note:
*Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.
***Plans C and F (including High Deductible F) are not available to "newly eligible" Medicare beneficiaries. As states enact or update their specific under age 65 requirements in relation to MACRA, this section will be updated accordingly.

Selective Issue

Applicants over the age of 65, or under age 65 in the states previously listed, and at least six months beyond enrollment in Medicare Part B will be selectively underwritten, which are year-round open enrollment states. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any health questions are answered "Yes," the applicant is not eligible for coverage. Applicants will be accepted or declined. Elimination endorsements will not be used.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Applicants who fall outside the established guidelines for standard rating could receive a premium rate increase of 10%, 20% or be declined (a chart detailing the height and weight class ratings can be found on page 24).

In the state of TX, premium rate-ups do not apply. Coverage will be declined for those applicants who are outside the established height and weight guidelines.

Health information, including answers to health questions on applications and claims information, is confidential and is protected by state and federal privacy laws. Accordingly, the Company does not disclose health information to any non-affiliated insurance company.

Application Dates

Open Enrollment

Up to six months prior to the month the applicant turns age 65.

Underwritten Cases

Up to 60 days prior to the requested coverage effective date.

Individuals whose employer group health plan coverage is ending can apply up to three months prior to the requested effective date of coverage.

Coverage Effective Dates

Coverage will be made effective as indicated below:

- Between age 64½ and 65 — The first of the month the individual turns age 65
- All Others — Application date or date of termination of other coverage, whichever is later

Replacements

A "replacement" takes place when an applicant terminates an existing Medicare supplement certificate and replaces it with a new Medicare supplement certificate. The Company requires a fully completed application when applying for a replacement certificate (both internal and external replacements).

A certificate owner wanting to apply for a nontobacco plan must complete a new application and qualify for coverage.

Certificate owners wishing to change their Risk Class rating because of weight loss must maintain that weight loss for at least 12 months. A new application is required and will be underwritten.

If an applicant has had a Medicare supplement certificate issued by the Company within the last 60 days, any new applications will be considered to be a replacement application. If more than 60 days has elapsed since prior coverage was in force, then applications will follow normal underwriting rules.

All replacements involving a Medicare supplement, Medicare SELECT or Medicare Advantage plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application. The replacement cannot be applied for on the exact same coverage and exact same company.

The replacement Medicare supplement certificate cannot be issued in addition to any other existing Medicare supplement, SELECT or Medicare Advantage plan.

Reinstatements

When a Medicare supplement certificate has lapsed and it is within 90 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements. Renewal commission rates will continue based on the certificate's duration.

When a Medicare supplement certificate has lapsed and it is more than 90 days beyond the last paid to date, the coverage cannot be reinstated. The client may, however, apply for new coverage. All underwriting requirements must be met before a new certificate can be issued.

Telephone Interviews

Random telephone interviews with applicants will be conducted on underwritten cases. Please be sure to advise your clients that we may be calling to verify the information on their application.

If there is a Power of Attorney signing the application, a health interview with the applicant will be required. If we are unable to perform an interview with the applicant, we will require two years of current medical records at the applicant's expense.

Medical and Pharmaceutical Information

The Company has implemented a process to support the collection of medical and pharmaceutical information for underwritten Medicare supplement applications. The "Authorization to Disclose Personal Information (HIPAA)" is included in the Agreement and Authorization section of the application. Medical and Prescription information noted on the application will be compared to the additional medical and pharmaceutical information received.

Certificate Delivery Receipt

Delivery receipts are required on all certificates issued in LA and WV.

Two copies of the delivery receipt will be included in the certificate package. One copy is to be left with the client. The second copy must be returned to the Company in the postage paid envelope included in the certificate package.

Guaranteed Issue Right

Some states may have additional Guaranteed Issue rights under state law. The situations listed below are based upon scenarios found in the Guide to Health Insurance.

Note: All plans are not Guaranteed Issue. Plans C and F (including High Deductible F) are not available to newly eligible Medicare beneficiaries.

“Newly Eligible” Medicare Beneficiary Defined by MACRA — In this subsection, the term ‘newly eligible Medicare beneficiary’ means an individual who is neither of the following: “(A) An individual who has attained age 65 before Jan. 1, 2020. “(B) An individual who was entitled to benefits under part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before Jan. 1, 2020.

While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, where offered.

Guaranteed Issue Situation	Client has the right to buy...	Client can/must apply for a Medigap policy...
Client is in Original Medicare and has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending. Note: In this situation, state laws may vary.	Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in client's state by any insurance company. If client has COBRA coverage, client can either buy a Medigap policy right away or wait until the COBRA coverage ends.	No later than 63 calendar days after the latest of these 3 dates: 1. Date the coverage ends. 2. Date on the notice the client gets, telling him/her that coverage is ending (the client receives one). 3. Date on a claim denial, if this is the only way the client knows that his/her coverage ended.
Client is in Original Medicare and has a Medicare SELECT policy. Client moves out of the Medicare SELECT plan's service area. Client can keep your Medigap policy or he/she may want to switch to another Medigap policy.	Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold by any insurance company in client's state or the state he/she is moving to.	As early as 60 calendar days before the date the client's Medicare SELECT coverage will end, but no later than 63 calendar days after the client's Medicare SELECT coverage ends.
Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy coverage otherwise ends through no fault of client.	Medigap Plan A, B, C*, D**, F*, High Deductible F*, G**, High Deductible G**, K or L that is sold in client's state by any insurance company.	No later than 63 calendar days from the date the client's coverage ends.

Note:
*Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.

Group Health Plan Proof of Termination

Proof of Involuntary Termination: If applying for Medicare supplement, Underwriting cannot issue coverage as Guaranteed Issue without proof that an individual's employer coverage is no longer offered. The following is required:

- Complete the Other Health Insurance section on the Medicare supplement application; and
- Provide a copy of the termination letter, showing date of and reason for termination, from the employer or group carrier

Proof of Voluntary Termination: Under the state specific voluntary terminations scenarios, the following proof of termination is required along with completing the Other Health Insurance section on the Medicare supplement application:

- Certificate of Group Health Plan Coverage
- In IA and WV, provide proof of change in benefits from employer or group carrier

Guaranteed Issue Rights for Voluntary Termination of Group Health Plan

Note: Plans C and F are not available to newly eligible Medicare beneficiaries (please see page 7 for the definition of "newly eligible").

While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, where offered.

State	Qualifies for Guaranteed Issue...
IA	If the employer sponsored plan's benefits are reduced, but does not include a defined threshold.
IL, TX	If the employer sponsored plan is primary to Medicare.
LA	No conditions — always qualifies.
WV	If the employer sponsored plan's benefits are reduced substantially.

For purposes of determining Guaranteed Issue eligibility due to a Voluntary Termination of an employer sponsored group welfare plan, a reduction in benefits will be defined as any increase in the insured's deductible amount or their coinsurance requirements (flat dollar copays or coinsurance percentage). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for Guaranteed Issue eligibility. This definition will be used to satisfy IA and WV requirements. Proof of coverage termination is required.

Guaranteed Issue Right for Loss of Medicaid Qualification

State	Open Enrollment Situation	Client has the right to buy
IA	Individuals who have exhausted their initial Open Enrollment period as a result of continued enrollment in Medicaid, are eligible for a 63 day Guarantee Issue period for Plan A. This period is effective the date they are moved from full Medicaid. Proof of this change in Medicaid should be submitted with the application.	Plan A
TX	Client loses eligibility for health benefits under Medicaid. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Medigap Plan A, B, C*, D**, F* (including High Deductible F*), G** (including High Deductible G**) K or L offered by any issuer; except that for persons under 65 years of age, it is a policy which has a benefit package classified as Plan A.

Note: *Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.

Guaranteed Issue Right for Loss of Medicaid following Lapse of Covid-19 Public Health Emergency

State	Description	Plans
IA, MI, MS	Guarantee issue right for individuals who miss their OE period during the Public Health Emergency due to continued Medicaid enrollment. Right starts upon notice of termination or disenrollment from Medicaid and ends 63 days later. Please submit a copy of the letter applicant received advising them that their coverage under Medicaid is terminating.	Any Medigap Plan offered by an insurer. Plan C and F are not available to newly eligible Medicare beneficiaries

Medicare Advantage (MA)

Medicare Advantage Open Enrollment Period

General Election Periods for Medicare Advantage	Time Frame	Allows for...
Annual Enrollment Period (AEP)	Oct. 15th – Dec. 7th of every year	• Enrollment selection for a MA plan • Disenrollment from a current MA plan • Enrollment selection for Medicare Part D
Medicare Advantage Open Enrollment Period (MA OEP)	Jan. 1st – March 31st of every year	• MA enrollees to disenroll from any MA plan and return to Original Medicare • Switch from one Medicare Advantage plan to another The MA OEP does not provide an opportunity to: • Switch from original Medicare to a Medicare Advantage plan • Switch from one Medicare Prescription Drug plan to another • Join, switch or drop a Medicare Medical Savings Account plan

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local State Health Insurance Assistance Program (SHIP) office for direction.

Medicare Advantage Proof of Disenrollment

If applying for Medicare supplement, Underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare, the MA plan must notify the member of his/her Medicare supplement Guaranteed Issue rights.

Disenroll during the Annual Election Period and Medicare Advantage Open Enrollment Period (MA OEP)

Complete the MA section on the Medicare supplement application; and

1. Send **ONE** of the following with the application
   a. A copy of the applicant's MA plan's termination notice
   b. Image of insurance ID card (only allowed if MA plan is being terminated)

If an individual is disenrolling outside AEP/MA OEP

1. Complete the MA section on the Medicare supplement application; and
2. Send a copy of the applicant's MA plan's disenrollment notice with the application.

For any questions regarding MA disenrollment eligibility, contact your State Health Insurance Assistance Program office or call 1-800-MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

Guaranteed Issue Rights

The situations listed below are based upon scenarios found in the Guide to Health Insurance.

Note: All plans are not Guaranteed Issue. Plans C and F (including High Deductible F) are not available to newly eligible Medicare beneficiaries. "Newly eligible" is defined as individuals who have attained age 65 on or after Jan. 1, 2020 or first become eligible for Medicare due to age, disability or end-stage renal disease, on or after Jan. 1, 2020. While Plans C and F are not available to these Medicare beneficiaries, Plans D, G and High Deductible G are available, only for newly eligible beneficiaries where offered.

Guaranteed Issue Situation	Client has the right to...	Client can/must apply for a Medigap policy...
Client's MA plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the plan's service area.	Buy a Medigap Plan A, B, C*, D**, G**, F*, K or L that is sold in the client's state by any insurance carrier. Client must switch to Original Medicare Plan.	As early as 60 calendar days before the date your health care coverage will end, but no later than 63 calendar days after your health care coverage ends. Medigap coverage can't start until your Medicare Advantage Plan coverage ends.
(Trial right) Client joined an MA plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to Original Medicare.	Buy any Medigap plan that is sold in your state by any insurance company.	As early as 60 calendar days before the date the client's coverage will end, but no later than 63 calendar days after his/her coverage ends. **Note:** The client's rights may last for an extra 12 months under certain circumstances.
(Trial right) Client dropped his/her Medigap policy to join an MA plan for the first time, has been in the plan less than one year and wants to switch back.	Obtain client's Medigap policy back if that carrier still sells it. If his/her former Medigap policy is not available, the client can buy a Medigap Plan A, B, C*, D**, G**, F*, K or L that is sold in his/her state by any insurance company.	As early as 60 calendar days before the date the client's coverage will end, but no later than 63 calendar days after his/her coverage ends. **Note:** The client's rights may last for an extra 12 months under certain circumstances.
Client leaves an MA plan because the company has not followed the rules, or has misled the client.	Buy Medigap plan A, B, C*, D**, G**, F*, K or L that is sold in the client's state by any insurance company.	No later than 63 calendar days from the date the client's coverage ends.

Note:
*Plans C and F are **not** available to newly eligible Medicare beneficiaries.
Plans D and G are **only available to newly eligible Medicare beneficiaries.

Premium Payment and Calculation Guidelines

Calculating Premium

Utilizing the Outline of Coverage

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine plan
- Determine if nontobacco or tobacco
- Find Age/Gender — Verify that the age and date of birth are the exact age as of the application date
- This will be your base monthly premium

Tobacco rates do not apply during Open Enrollment or Guaranteed Issue situations in the following states:
IA, IL, LA, MI

Utilizing the Calculate Your Premium Form

- Enter the base premium on line #2 and proceed with the instructions that follow

Types of Medicare Certificate Ratings

Community rated
The same monthly premium is charged to everyone who has the Medicare certificate, regardless of age. Premiums are the same no matter how old the applicant is. Premiums may go up because of inflation and other factors, but not based on age.

Issue age rated
The premium is based on the age the applicant is when the Medicare certificate is bought. Premiums are lower for applicants who buy at a younger age, and won't change as they get older. Premiums may go up because of inflation and other factors, but not because of applicant's age.

Attained age rated
The premium is based on the applicant's current age so the premium goes up as the applicant gets older. Premiums are low for younger buyers, but go up as they get older. In addition to change in age, premiums may also go up because of inflation and other factors.

Note: If a premium is paid by a business account, refer to the "Business Checks" section of this guide to determine if acceptable, and if so, which rate type will be applied.

Rate Type Available by State

State	Tobacco / Nontobacco Rates	Gender Rates	Attained, Issue, or Community Rated	Tobacco Rates During OE	HHD Type	HHD	Class Rating
AL	Y	Y	A	Y	Cohab	10%	Y
GA	Y	Y	I	Y	Cohab	10%	Y
IA	Y	Y	A	N	Cohab	10%	Y
IL	Y	Y	A	N	Cohab	10%	Y
LA	Y	Y	A	N	Cohab	10%	Y
MI	Y	Y	A	N	Cohab	10%	Y
MS	Y	Y	A	Y	Cohab	10%	Y
SC	Y	Y	A	Y	Cohab	10%	Y
TX	Y	Y	A	Y	Special	10%	N
WV	Y	Y	A	Y	Cohab	10%	Y

Due to changes and timing, not all states may currently be available for new business sales. Please check the available products information on Sales Professional Access, Products link.

Anniversary Re-rating

Certificate owners receive increases only on their certificate anniversary in all states.

Early Enrollment Discount (not available in all states)

Clients may be eligible for the Early Enrollment Discount if they are between the ages of 65 and 73 when the policy is issued. Discounts start at 12% and decrease each year as the client ages.

No manual calculation necessary, discount is automatically applied to e-app and your state-specific Outline of Coverage.

Early Enrollment Discount available in GA.

Household Discount (not applicable in all states)
Based on the state, one of the following household discounts are available:

Standard Co-habitation (Co-hab) Household Discount Language —
Applicant may be eligible for the household discount if he/she either:

- Resides with a spouse or civil union/domestic partner; or
- Has resided with as many as three adults age 60 or older for the last 12 months

Standard Two-Certificate (2-Cert) Household Discount Language —
Applicant may be eligible for the household discount if:

- Applicant resides with a spouse or civil union partner or has continuously resided for the past 12 months with as many as three household members who are Medicare eligible; and
- The spouse, civil union partner or household member either has an existing Medicare supplement plan with or is also applying for and is issued coverage with the Company

These requirements generally apply everywhere. The table on page 22 states which type of discount is offered in each state. There are state specific variations. State special certificate language is included in the Household Discount State Special Language Table on page 23. There are state-specific variations, so please see a specific state application.

How to determine eligibility for the household discount:

1. Refer to the Household Discount section on the application.
2. If question 1 is answered "Yes," the individual qualifies.

Household Discount Standard Certificate Language

Co-Habitation Certificate (Co-Hab)	Two-Certificate (2-Cert)
You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other adults who are age 60 or older. If you live with another adult who is your legal spouse, we will waive both the one-year requirement and the age 60 requirement. For the purposes of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. Your premium will be reduced by the percentage shown on the certificate schedule. Your certificate's household premium discount will be removed if the other adult no longer resides with you (other than in the case of his or her death).	You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other Medicare-eligible adults who own or are issued a Medicare supplement certificate underwritten by us. If you live with another adult who is your legal spouse, we will waive the one-year requirement. For the purposes of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. Your premium will be reduced by the percentage shown on the certificate schedule. Your certificate's household premium discount will be removed if the other Medicare supplement certificate owner chooses to terminate his or her Medicare supplement certificate or he or she no longer resides with you (other than in the case of his or her death).

Household Discount State Special Certificate Language

State	Certificate Language
TX	You are eligible for a household premium discount if for the past year you have resided with at least one, but no more than three, other adults. If you live with another adult who is your legal spouse, we will waive the one-year requirement. For the purposes of this discount, a domestic partner will be considered a legal spouse when such partnerships are valid and recognized in your state of residence. We may request additional documentation to determine eligibility. Your premium will be reduced by the percentage shown on the certificate schedule. Your certificate's household premium discount will be removed if the other adults no longer reside with you (other than in the case of their deaths).

Definition of Domestic Partner

Either partner of an unmarried couple (includes same sex) in a relationship considered as being equivalent to marriage for the purpose of extending certain legal rights and benefits.

Definition of Civil Union Partner

Partners who are recognized by a state or government as conferring all or some of the rights conferred by marriage.

Class Rating (not applicable in all states and only applies to fully underwritten applications)

How to determine class rating:

1. Follow the instructions on the Calculate Your Premium form.
2. Complete the form and return with the application.

Height and Weight Chart for States WITH Class Rating

Check your state-specific Outline of Coverage to determine if the class rating is applicable in your state.

Eligibility

Find the applicant's height in the left-hand column and look across the row to find the weight. If the weight is in the Decline column, the applicant is not eligible for coverage at this time.

Rate Adjustment

The column heading above the weight indicates the appropriate rate adjustment, if any (risk class).

Height	Decline Weight	Class I Weight	Standard Weight	Class I Weight	Class II Weight	Decline Weight
4' 2"	< 54	54 - 60	61 - 110	111 - 128	129 - 145	146 +
4' 3"	< 56	56 - 62	63 - 114	115 - 133	134 - 151	152 +
4' 4"	< 58	58 - 65	66 - 119	120 - 138	139 - 157	158 +
4' 5"	< 60	60 - 67	68 - 123	124 - 143	144 - 163	164 +
4' 6"	< 63	63 - 70	71 - 128	129 - 149	150 - 170	171 +
4' 7"	< 65	65 - 73	74 - 133	134 - 154	155 - 176	177 +
4' 8"	< 67	67 - 75	76 - 138	139 - 160	161 - 182	183 +
4' 9"	< 70	70 - 78	79 - 143	144 - 166	167 - 189	190 +
4' 10"	< 72	72 - 81	82 - 148	149 - 172	173 - 196	197 +
4' 11"	< 75	75 - 84	85 - 153	154 - 178	179 - 202	203 +
5' 0"	< 77	77 - 87	88 - 158	159 - 184	185 - 209	210 +
5' 1"	< 80	80 - 89	90 - 164	165 - 190	191 - 216	217 +
5' 2"	< 83	83 - 92	93 - 169	170 - 196	197 - 224	225 +
5' 3"	< 85	85 - 95	96 - 175	176 - 203	204 - 231	232 +
5' 4"	< 88	88 - 99	100 - 180	181 - 209	210 - 238	239 +
5' 5"	< 91	91 - 102	103 - 186	187 - 216	217 - 246	247 +
5' 6"	< 93	93 - 105	106 - 192	193 - 223	224 - 254	255 +
5' 7"	< 96	96 - 108	109 - 197	198 - 229	230 - 261	262 +
5' 8"	< 99	99 - 111	112 - 203	204 - 236	237 - 269	270 +
5' 9"	< 102	102 - 115	116 - 209	210 - 243	244 - 277	278 +
5' 10"	< 105	105 - 118	119 - 216	217 - 250	251 - 285	286 +
5' 11"	< 108	108 - 121	122 - 222	223 - 258	259 - 293	294 +

Height	Decline Weight	Class I Weight	Standard Weight	Class I Weight	Class II Weight	Decline Weight
6' 0"	< 111	111 - 125	126 - 228	229 - 265	266 - 302	303 +
6' 1"	< 114	114 - 128	129 - 234	235 - 272	273 - 310	311 +
6' 2"	< 117	117 - 132	133 - 241	242 - 280	281 - 319	320 +
6' 3"	< 121	121 - 136	137 - 248	249 - 288	289 - 328	329 +
6' 4"	< 124	124 - 139	140 - 254	255 - 295	296 - 336	337 +
6' 5"	< 127	127 - 143	144 - 261	262 - 303	304 - 345	346 +
6' 6"	< 130	130 - 147	148 - 268	269 - 311	312 - 354	355 +
6' 7"	< 134	134 - 150	151 - 275	276 - 319	320 - 363	364 +
6' 8"	< 137	137 - 154	155 - 282	283 - 327	328 - 373	374 +
6' 9"	< 140	140 - 158	159 - 289	290 - 335	336 - 382	383 +
6' 10"	< 144	144 - 162	163 - 296	297 - 344	345 - 392	393 +
6' 11"	< 147	147 - 166	167 - 303	304 - 352	353 - 401	402 +
7' 0"	< 151	151 - 170	171 - 311	312 - 361	362 - 411	412 +
7' 1"	< 155	155 - 174	175 - 318	319 - 369	370 - 421	422 +
7' 2"	< 158	158 - 178	179 - 326	327 - 378	379 - 431	432 +
7' 3"	< 162	162 - 183	184 - 333	334 - 387	388 - 441	442 +
7' 4"	< 166	166 - 187	188 - 341	342 - 396	397 - 451	452 +

Height and Weight Chart for States WITHOUT Class Rating
Check your state-specific Outline of Coverage to determine if the class rating is applicable in your state.

Eligibility
Find the applicant's height in the left-hand column and look across the row to find the weight. If it is in the Decline column, the applicant is not eligible for coverage at this time.

Height	Decline Weight	Standard Weight	Decline Weight
4' 2"	< 54	54 - 145	146 +
4' 3"	< 56	56 - 151	152 +
4' 4"	< 58	58 - 157	158 +
4' 5"	< 60	60 - 163	164 +
4' 6"	< 63	63 - 170	171 +
4' 7"	< 65	65 - 176	177 +
4' 8"	< 67	67 - 182	183 +
4' 9"	< 70	70 - 189	190 +
4' 10"	< 72	72 - 196	197 +
4' 11"	< 75	75 - 202	203 +
5' 0"	< 77	77 - 209	210 +
5' 1"	< 80	80 - 216	217 +
5' 2"	< 83	83 - 224	225 +
5' 3"	< 85	85 - 231	232 +
5' 4"	< 88	88 - 238	239 +
5' 5"	< 91	91 - 246	247 +
5' 6"	< 93	93 - 254	255 +
5' 7"	< 96	96 - 261	262 +
5' 8"	< 99	99 - 269	270 +
5' 9"	< 102	102 - 277	278 +
5' 10"	< 105	105 - 285	286 +
5' 11"	< 108	108 - 293	294 +
6' 0"	< 111	111 - 302	303 +
6' 1"	< 114	114 - 310	311 +

Height	Decline Weight	Standard Weight	Decline Weight
6' 2"	< 117	117 - 319	320 +
6' 3"	< 121	121 - 328	329 +
6' 4"	< 124	124 - 336	337 +
6' 5"	< 127	127 - 345	346 +
6' 6"	< 130	130 - 354	355 +
6' 7"	< 134	134 - 363	364 +
6' 8"	< 137	137 - 373	374 +
6' 9"	< 140	140 - 382	383 +
6' 10"	< 144	144 - 392	393 +
6' 11"	< 147	147 - 401	402 +
7' 0"	< 151	151 - 411	412 +
7' 1"	< 155	155 - 421	422 +
7' 2"	< 158	158 - 431	432 +
7' 3"	< 162	162 - 441	442 +
7' 4"	< 166	166 - 451	452 +

Enrollment/Certificate Fee

There will be a one-time application fee of $25.00 that will be collected with each applicant's initial payment. For a husband and wife written on the same application, $50.00 in fees must be collected. This will not affect the renewal premiums.

Completing the Premium on the Method of Payment Form

Premiums are calculated based upon the applicant's exact age at the time of application, not the age as of the requested coverage effective date.

Collection of Premium

At least one month's premium must be submitted with the application.

1. Money orders, cashier's checks and counter checks are only acceptable if obtained by the applicant. Third party payors cannot obtain a money order or cashier's check on behalf of the applicant.
2. **Note:** The company does not accept post-dated checks or payments from third parties. Immediate family and domestic partners are acceptable payors. We do not accept checks or payments from foundations as premium.

Initial Premium Payment Options

1. **Automatic Bank Withdrawal upon issue**
   - The applicant must use a bank account that contains their name on the account
   - If ACH, we need both the account number and the routing number to process payment
   - The account number can be from a checking or savings account
2. **Check**
   - Available only if the applicant is going to wet sign their application
   - Check is cashed upon certificate issue

Ongoing Premium Payment Options

1. **Monthly Automatic Bank Withdrawal**
   Options Available on Application and e-App
     - 1st through the 28th or the last day of every month
     - Week (1st, 2nd, 3rd, 4th, last)
     - Weekday (Mon, Tue, Wed, Thu, Fri)
2. **Check**
   - Insured may mail a premium check to the Company
   - Quarterly
   - Semiannually
   - Annually

Business Checks

If premium is paid by a business account, complete the information located on the Payer Information section (Part II) of the Method of Payment Form. Business checks are acceptable if they are submitted for the business owner, the owner's spouse, or retirees of the business.

Premium Receipt

The Premium Receipt must be completed and provided to applicant if premium is collected.

Note: <u>**Do not**</u> mail a copy of the receipt with the application.

Shortages

The company will communicate with the producer by telephone, email or FAX in the event of a premium shortage. The application will be held in pending until the balance of the premium is received. Producers may communicate with Underwriting by calling 1-800-893-6517 or by FAX at 402-977-1920.

Our General Administrative Rule — 12-Month Rate
Our current administrative practice is not to adjust rates for 12 months from the effective date of coverage.

Refunds
In the event of rejection, incomplete submission, overpayment, cancellations, etc., the company will not cash checks. The company will destroy all checks and refund credit cards.

Initial Premium Payment Processing and Refunding Medicare Supplement Applications Only		
Initial Premium Payment Method	Payment is Processed	Handling the Refund when Certificate is Not Issued
ACH	At certificate issue	N/A; premium wasn't withdrawn
Personal check with individual application	At certificate issue	Check is destroyed; not returned
Personal check with dual application	When the first person's certificate is issued	Refund mailed within 30 business days if second person's certificate isn't issued*
Bank draft, cashier's check, money order	When underwriting decision is made (issue, reject, withdraw, incomplete)	Refund mailed within 30 business days*

*Refunds are sent to the applicants under separate cover from the letter indicating the reject, withdrawn or incomplete status of their application.

Application

Properly completed applications should be finalized within 5-7 days of receipt at the company. The ideal turnaround time provided to the producer is 11-14 days, including mail time.

Application Sections

The application must be completed in its entirety. Please be sure to review your applications for the following information before submitting.

Administrative Information

1. **Agent Writing Number**
   a. Enter your agent writing number or Social Security number.
   Note: You do NOT need to complete the FAV Key, Auth #, and Keyline fields.

Plan Information Section

1. Complete the entire section.
2. Indicate the plan or certificate form selected, requested effective date and the certificate delivery option.

Applicant Information

1. Please complete the applicant's residence address in full. If premium notices are to be mailed to an address other than the applicant's residence address, please complete the mailing address in full.
2. Age and Date of Birth are the **exact age** as of the **application date**.
3. Height/Weight — These are required on underwritten cases.
4. Answer the tobacco question, this includes any nicotine or electronic cigarette (e-cigarette) use. (Refer to the Calculating Premium section of this Guide for a list of states where tobacco rates do not apply during Open Enrollment or Guaranteed Issue situations.)
5. Indicate if the applicant would like to receive the Explanation of Benefits (EOBs) online.

Medicare Information

1. Medicare claim number, also referred to as the Medicare Beneficiary Identifier (MBI) number, is vital for electronic claims payment.
2. Please indicate if the applicant is covered under Parts A and B of Medicare.

Household Premium Discount (not available in all states)

1. If question 1 is answered "Yes," the individual qualifies.
2. This information is necessary for premium calculation.

Previous or Existing Coverage Information

1. Verify if the applicant is covered through his/her state Medicaid program. If Medicaid is paying for benefits beyond the applicant's Part B premium or the Medicare supplement premium for this certificate, then the applicant is not eligible for coverage.
2. If the applicant is replacing another Medicare supplement certificate, complete question 4 and include the replacement notice.
3. If the applicant is leaving a Medicare Advantage plan, complete question 5 and include the replacement notice.
4. If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union plan, employer group health plan, or other non-Medicare supplement coverage, complete question 6.

Please answer all of the following questions

1. If the applicant is applying during a Guaranteed Issue period, be sure to include proof of eligibility.
2. If either applicant A or B answered "YES" to question 7 OR BOTH questions 8 and 9 in Section F, skip to Section I — Agreement and Authorization.

Note: In Kentucky, if any applications contain an error or omission, it will either need to be corrected and initialed or a new application will be required. Voice amendments for Medicare supplement applications taken in the state of Kentucky are not permitted.

Health Information

1. If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the health questions.
2. If applicant is not considered to be in Open Enrollment or a Guaranteed Issue situation, all health questions must be answered.

Note: To be considered eligible for coverage, all health questions must be answered "No." For questions on how to answer a particular health question, see the **Health Questions** section of this Guide for clarification.

Medication Information

1. If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the medication information section.
2. If applicant is not considered to be in Open Enrollment or a Guaranteed Issue situation, all medication information must be listed as indicated.

For compliance purposes, sections G — Health Information and H — Medication Information (application pages 5 and 6, respectively) must be included with submitted applications.

While these pages are not required to be completed during Open Enrollment and Guaranteed Issue situations, they must be submitted for a complete contract.

Agreement and Authorization

1. Applicant acknowledges receiving the Guide to Health Insurance and Outline of Coverage. You are required to leave these two documents with the client at the time the application is completed.
2. Applicant agrees to the Authorization to Disclose Personal Information.
3. Signatures and dates: required by applicant(s).
4. If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative. The Power of Attorney needs to sign the applicant's name on the application. If Applicant's name is John Smith, and the Power of Attorney is Mary Smith, the application should be signed as John Smith by Mary Smith, Power of Attorney or Mary Smith, Power of Attorney for John Smith.

To be Completed by Producer

The producer(s) must certify that he/she:

1. Provided the applicant with a copy of the replacement notice if applicable.
2. Accurately recorded in the application the information supplied by the applicant.
3. Has interviewed the proposed applicant.
4. Signed and dated the application.

The licensed agent must be appointed with the underwriting company in the state the application was signed in. For example, if an application is being signed in state A, the producer must be appointed in state A (even if the applicant lives in state B).

If an application is taken in Texas or Michigan, it must be signed by the applicant in the state of Texas or Michigan, respectively.

Regardless of state, writing agents must always have an EFFECTIVE license date prior to an application being signed. This is state law.

Note: Certificate will not issue unless the writing agent also has an appointment with the Company.

Pennsylvania is a pre-appointment state for the writing agents only. (This means that the writing agent in these states MUST have their license submitted to the Company and their appointments effective at the state level prior to submitting a certificate application, there are no exceptions.)

Note: Applicant's signature must match the name of the applicant on the application. In rare cases where the applicant cannot sign his/her name, a mark ("X") is acceptable. For their own protection, producers are advised against acting as sole witness.

Health Questions

Unless an application is completed during Open Enrollment or a Guaranteed Issue period, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare supplement coverage if any of the health questions are answered “Yes”. For a list of uninsurable conditions and the related medications associated with these conditions, please refer to the next pages in this guide.

There may be, however, situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition. Those conditions are listed in the health questions.

A condition is considered to be controlled if there have been no changes in treatment or medications for at least two years. If this situation exists and you would like consideration to be given to the application, answer the appropriate question “Yes,” and attach an explanation stating how long the condition has existed and how it is being controlled. Be sure to include the names and dosages of all prescription medications.

People with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complicating conditions that are specified in the health question, are not eligible for coverage. For purposes of this question, hypertension (high blood pressure) is considered a heart condition.

Some additional questions to ask your client to determine if he/she does have a complication include:

1. Does he/she have eye/vision problems?
2. Does he/she have numbness or tingling in the toes or feet?
3. Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with well-controlled cases of hypertension and diabetes.

A case is considered to be well controlled if the person is taking no more than:

- Two oral medications for diabetes and;
- Two medications for hypertension

A combination of insulin and one oral medication would be the same as two oral medications if the diabetes were well controlled.

In general, to verify stability, there should be no changes in the dosages or medications in the past two years. Individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower.

2 x 2 Rule

No More Than **TWO** Medications for Blood Pressure and No More than **TWO** Medications for Diabetes Management	With No Changes to the medication, dosage or frequency in the past **TWO** years.

Uninsurable Health Conditions

Applications should not be submitted if the applicant has the following conditions:

AIDS **Alzheimer's Disease** **ARC** **Any cardiopulmonary disorder requiring oxygen** **Cirrhosis**	**Chronic Hepatitis** • Chronic Hepatitis B • Chronic Hepatitis C • Chronic Hepatitis D • Autoimmune Hepatitis • Chronic Active Hepatitis • Chronic Steatohepatitus

Chronic Kidney/Renal Disease
- Chronic Nephritis
- Chronic Glomerulonephritis
- Chronic protein loss in the urine (proteinuria)
- Requiring 4 or more MD office visits per year in the follow up of renal disease
- Chronic Renal Insufficiency
- Hypertensive Chronic Renal Disease
- Nephrotic Syndrome
- Stage 3, Stage 4 or Stage 5 Chronic Kidney Disease

Chronic Obstructive Pulmonary Disease (COPD)
Other chronic pulmonary disorders to include:
- Asbestosis
- Chronic Bronchitis
- Chronic Cardiopulmonary Disease
- Chronic Obstructive Lung Disease (COLD)
- Chronic Asthma
- Chronic Interstitial Lung Disease
- Chronic Pulmonary Fibrosis
- Cystic Fibrosis
- Pulmonary Hypertension
- Sarcoidosis
- Bronchiectasis
- Scleroderma
- Emphysema

End-Stage Renal Disease (ESRD)

Kidney Disease requiring dialysis

Kidney (Renal) Failure/End-Stage Renal Disease

Any kidney disorder that has the applicant being evaluated for, or who is currently on dialysis

Amyotrophic Lateral Sclerosis
(Lou Gehrig's Disease)

Lupus – Systematic

Multiple Sclerosis

Myasthenia Gravis

Organ Transplant

Osteoporosis with Fracture

Parkinson's Disease

Pulmonary Hypertension

Senile Dementia

Other cognitive disorders to include:
- Mild Cognitive Impairment (MCI)
- Delirium
- Organic Brain Disorder
- Cerebrovascular Disease with Cognitive Deficits
- Dissociative Amnesia
- Huntington's Chorea (Huntington's Disease)
- Post-Concussion Syndrome with residual problems

In addition to the above conditions, the following will also lead to a decline:
- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, further diagnostic evaluation, treatment or therapy

Partial List of Medications Associated with Uninsurable Health Conditions

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

Medication	Condition
3TC	AIDS
Acetate	Prostate Cancer
Accuneb	COPD
Aducanumab	Alzheimers
Alkeran	Cancer
Amantadine	Parkinson's Disease
Ampyra	Multiple Sclerosis
Anoro Ellipta	COPD
Apokyn	Parkinson's Disease
Aptivus	HIV
Aricept	Dementia
Aricept ODT	Alzheimer's Disease
Artane	Parkinson's Disease
Atripla	HIV
Aubagio	Multiple Sclerosis
Avonex	Multiple Sclerosis
Azilect	Parkinson's Disease
AZT	AIDS
Baclofen	Multiple Sclerosis
Bafiertam	Multiple Sclerosis
BCG	Bladder Cancer
Betaseron	Multiple Sclerosis
Bicalutamide	Prostate Cancer
Breo	COPD
Brovana	COPD
Carbidopa	Parkinson's Disease
Casodex	Prostate Cancer
Cerefolin	Dementia
Cogentin	Parkinson's Disease
Cognex	Dementia
Combivir	HIV
Comtan	Parkinson's Disease
Copaxone	Multiple Sclerosis
Crixivan	HIV
Cytoxan	Cancer, Severe Arthritis, Immunosuppression
D4T	AIDS
DDC	AIDS
Daliresp	COPD
DDI	AIDS
DES	Cancer

Medication	Condition
Donepezil	Alzheimer's Disease
Dornase Alfa	Chronic Pulmonary Disorder
DuoNeb	COPD
Ebixa	Alzheimer's Disease
Eldepryl	Parkinson's Disease
Elexacaftor-Tezacaftor-Ivacaftor	Chronic Pulmonary Disorder
Eligard	Prostate Cancer
Embrel	Rheumatoid Arthritis
Emtriva	HIV
Enlon	Myasthenia Gravis
Epivir	HIV
Epogen	Kidney Failure, AIDS
Ergoloid	Dementia
Esbriet	Chronic Pulmonary Disorder
Exelon	Dementia
Extavia	Multiple Sclerosis
Fuzeon	HIV
Galantamine	Dementia
Geodon	Schizophrenia
Gilenya	Multiple Sclerosis
Glatopa	Multiple Sclerosis
Gold	Rheumatoid Arthritis
Haldol	Psychosis
Herceptin	Cancer
Hydergine	Dementia
Hydrea	Cancer
Hydroxyurea	Melanoma, Leukemia, Cancer
Imuran	Immunosuppression, Severe Arthritis
Incruse Ellipta	COPD
Indinavir	AIDS
Insulin (MN Only)	Diabetes*
Interferon	AIDS, Cancer, Hepatitis
Invega	Schizophrenia
Invirase	AIDS
Ivacaftor	Chronic Pulmonary Disorder
Kaletra	HIV
Kemadrin	Parkinson's Disease

Medication	Condition
Novatrone	Multiple Sclerosis
Nucala	Chronic Pulmonary Disorder
Ocrevus	Multiple Sclerosis
OFEV	Chronic Pulmonary Disorder
Paraplatin	Cancer
Parlodel	Parkinson's Disease
Permax	Parkinson's Disease
Pirfenidone	Chronic Pulmonary Disorder
Plegridy	Multiple Sclerosis
Ponvory	Multiple Sclerosis
Prezista	HIV
Procrit	Kidney Failure, AIDS
Prolixin	Psychosis
Prostigmin	Myasthenia Gravis
Provenge	Prostate Cancer
Radicaca	ALS
Razadyne	Dementia
Razadyne ER	Alzheimer's Disease
Remicade	Rheumatoid Arthritis
Reminyl	Dementia
Remodulin	Pulmonary Hypertension
Requip	Parkinson's Disease
Rescriptor	HIV
Retrovir	AIDS
Rebif	Multiple Sclerosis
Reyataz	HIV
Rilutek	Amyotrophic Lateral Sclerosis
Riluzole	ALS
Risperdal	Psychosis
Rivastigmine	Dementia
Sandimmune	Immunosupression, Severe Arthritis
Selzentry	HIV
Sinemet	Parkinson's Disease
Stalevo	Parkinson's Disease
Stelazine	Psychosis
Stiolto Respimat	COPD
Sustiva	AIDS
Symmetrel	Parkinson's Disease
Tacrine	Dementia
Tasmar	Parkinson's Disease
Tecfidera	Multiple Sclerosis
Teslac	Cancer
Kesimpta	Multiple Sclerosis
Lasix/Furosemide (>60mg/day)	Heart Disease
L-Dopa	Parkinson's Disease
Lemtrada	Multiple Sclerosis
Letairis	Cancer, Pulmonary Hypertension
Leukeran	Cancer, Severe Arthritis, Immunosuppression
Leuprolide	Prostate Cancer
Leuprolide Acetate	Prostate Cancer
Levodopa	Parkinson's Disease
Lexiva	HIV
Lioresal	Multiple Sclerosis
Lomustine	Cancer
Lumacaftor-Ivacaftor	Chronic Pulmonary Disorder
Lupron	Cancer
Lupron Depot	Prostate Cancer
Lupron Depot-Ped	Prostate Cancer
Mavenclad	Multiple Sclerosis
Mayzent	Multiple Sclerosis
Megace	Cancer
Megestrol	Cancer
Mellaril	Psychosis
Melphalan	Cancer
Memantine	Alzheimer's Disease
Methotrexate (>25mg/wk)	Rheumatoid Arthritis
Metrifonate	Dementia
Mirapex	Parkinson's Disease
Mitoxantrone	Multiple Sclerosis
Myleran	Cancer
Mytelase	Myasthenia Gravis
Namenda	Alzheimer's Disease
Namenda XR	Alzheimer's Disease
Namzaric	Alzheimer's Disease
Natrecor	CHF
Navane	Psychosis
Nelfinavir	AIDS
Neoral	Immunosuppression, Severe Arthritis
Neupro	Parkinson's Disease
Nintedanib	Chronic Pulmonary Disorder
Nintedanib Esylate	Chronic Pulmonary Disorder
Norvir	HIV

Medication	Condition
Thiotepa	Cancer
Thorazine	Psychosis
Trelegy Ellipta	COPD
Trelstar-LA	Prostate Cancer
Triptorelin	Prostate Cancer
Trizivir	HIV
Tudorza	COPD
Tysabri	Multiple Sclerosis
Valycte	CMV, HIV
VePesid	Cancer
Viadur	Prostate Cancer
Videx	HIV

Medication	Condition
Vincristine	Cancer
Viracept	HIV
Viread	HIV
Vumerity	Multiple Sclerosis
Zanosar	Cancer
Zelapar	Parkinson's Disease
Zerit	HIV
Ziagen	HIV
Zinbryta	Multiple Sclerosis
Ziprasidone	Schizophrenia
Zolandex	Cancer
Zometa	Hypercalcemia in Cancer

* Coverage is not available for individuals in Minnesota with diabetes.

Mailing Applications to Prospects

Mailing a completed application adds a few steps to the normal sales process. Below is a brief description of the necessary steps.

You will:

1. Ask the prospect the questions on the application and required forms; mail the completed application and required forms to the prospect for their review and signature.
2. Tell the prospect that they need to carefully review the application and forms for completeness and accuracy and then sign.
3. Have the prospect return the signed application, forms and premium payment to you in a postage paid envelope.
4. Upon return of the application and other forms, verify that all the required forms are completed and signed.
5. Submit the application through the usual channel; and
6. When issued, deliver the policy according to current policy delivery guidelines.

Always remember:

- You must be licensed to sell in the state where the prospect is at the time of solicitation
- The applicant's state of residence controls the application, forms and premium
- The client must return the signed applications, forms and premium payment to you and should not submit them directly to Mutual of Omaha
- Incomplete application submissions will be returned to you, so review thoroughly
- If you solicited the business, you must be the one to sign the corresponding application
- You cannot sign blank applications
- It is not acceptable to mail blank applications, brochures and outlines as prospecting materials

If you have questions, please call Sales Support at (800) 890-0349.

Required Forms

Application
Only current Medicare supplement applications may be used in applying for coverage. We will attach a copy of the application to the certificate to make it part of the contract.

The producer or designated office staff is responsible for submitting completed applications.

Producer Information Checklist
Producers must include their name and Agent Writing Number or Social Security number. A maximum of two producers are allowed and they should indicate the commission percentage shares, which must total 100%.

Commission Code is required only if the producer is not appointed or licensed or is changing brokerage firms.

Method of Payment Form
Complete this required form regarding payment options and submit with all applications.

Premium Receipt and Notice of Information Practices
Receipt must be completed and provided to applicant as receipt for premium collected. Notice must be provided to applicant.

Replacement Form
The replacement form must be signed and submitted with the application when replacing any Medicare supplement or Medicare Advantage application. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application.

Agent or Witness Certification for Non-English Speaking and/or Reading Applicants
If the applicant does not speak English, this form is to be completed by the agent if agent is translating or a witness if a witness is translating. A witness cannot be a relative or a family member. A copy must be submitted with the application and a copy left with the applicant.

Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was passed March 26, 2015, as a means to help reduce the cost of Medicare by reducing first dollar coverage provided by supplemental insurance plans. ***The Act prohibits individuals who become eligible for Medicare on Jan. 1, 2020, or after, from purchasing a Medicare supplement certificate that covers the Part B Deductible.*** This includes Medicare supplement Plans C, F, High Deductible F (and Minnesota and Wisconsin Part B deductible coverage).

Important note: As a number of states are in the process of enacting or updating their specific legislation/regulation requirements in relation to MACRA, this section will be updated accordingly.

Medicare-eligibility through Dec. 31, 2019
For your clients who were eligible for Medicare Part A prior to Jan. 1, 2020, their Medicare options are the same as they've always been. They can keep their existing plans or purchase any that cover the Part B deductible.

For example, if a client would like to purchase a Plan F, they would need to be eligible for Medicare Part A prior to Jan. 1, 2020.

Medicare-eligibility Jan. 1, 2020 and after
The MACRA rule will impact your clients who become Medicare-eligible after Dec. 31, 2019, as they're considered newly eligible and won't be able to purchase plans that cover the Part B deductible. "Newly Eligible" Medicare Beneficiary Defined by MACRA — In this subsection, the term 'newly eligible Medicare beneficiary' means an individual who is neither of the following: "(A) An individual who has attained age 65 before Jan. 1, 2020. "(B) An individual who was entitled to benefits under Part A pursuant to section 226(b) or 226A, or deemed to be eligible for benefits under section 226(a), before Jan. 1, 2020.

Additionally, MACRA makes Plans D and G the guaranteed issue plans for newly eligible Medicare beneficiaries (as of Jan. 1, 2020) for the specified period under current law that name Plans C or F for current beneficiaries.

Medicare Supplement Plan Choices as of Jan. 1, 2020		
Medicare Supplement Plans Available	Medicare-eligibility through Dec. 31, 2019	Medicare-eligibility on or after Jan. 1, 2020
	A, C, D, F, High-Deductible F, G, High-Deductible Plan G, N	A, D, G, High-Deductible Plan G, N

Frequently Asked Questions about MACRA

Question	Answer
Are clients currently on Plan C and Plan F "Grandfathered"?	Clients who currently have Plan C or Plan F will be "Grandfathered" or excluded from the MACRA provision. In addition, individuals eligible for Medicare on or before Dec. 31, 2019, will be eligible to purchase a Plan C or Plan F, subject to carrier guidelines, and will be "Grandfathered." The Company will continue to offer Plan C and Plan F to those eligible.
If a client is going on Medicare in 2019 and is considering purchasing Plan C or F, can they still purchase it?	Yes. Starting in 2020, Medigap Plan C or F can no longer be sold to beneficiaries who become "newly eligible" for Medicare on or after Jan. 1, 2020. Newly eligible Medicare beneficiaries are those who attain age 65 on or after Jan. 1, 2020 or become entitled to Medicare Part A by reason of disability or ESRD on or after Jan. 1, 2020. Individuals who are enrolled in Medicare before 2020 can still purchase these plans and will be able to keep their plan as long as they pay their premiums.
If an insured client is currently enrolled in Plan C or F, does the client need to do anything?	No, the customer does not need to take any action. Plans C and F will be available for consumers eligible to purchase in 2020 and beyond if the customer is Medicare-eligible prior to Jan. 1, 2020.
Can my client, whose birthday is Jan. 1, 1955, purchase either a High-Deductible Plan F (HDF) or High-Deductible Plan G (HDG)? Or just HDG?	An individual (born Jan. 1, 1955) with a birthday on Jan. 1, 2020 is eligible for Medicare on Dec. 1, 2019. This is consistent with the Medicare eligibility rules. This same individual is defined to be, and CMS recognized to be, a "newly eligible Medicare beneficiary" on Jan. 1, 2020, and as such cannot purchase a Plan C or F. They can purchase a Medigap certificate on Dec. 1, 2019, but it cannot be Plan C or F.
If clients want to leave Plan F, is there a guaranteed issue route to another plan?	The Company will not make special guaranteed issue rules for individuals on Plan F. If a customer would like to move to another plan, the individual would have to meet the underwriting requirements for that particular state.

If a client is currently on a Medicare Advantage plan, but wants to convert his or her coverage back to a Medicare supplement Plan C or F, can they do so without underwriting?	If an eligible customer would like to move to another plan, the individual would have to meet the underwriting requirements for his or her particular state. Please refer to our Medicare Advantage section on pages 16 and 17 of this guide for additional details.

Note: As additional questions and clarifications regarding MACRA are received, this section will be updated.

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