MEDMUTUAL PROTECT™
A Medical Mutual® Company

Insurance benefits provided by:
MedMutual Life Insurance Company

Medicare Supplement
Underwriting Guidelines and Agent Instructions

MEDMUTUAL PROTECT™
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Contents

Contacts

Administration Office Mailing Information

Mailing Address	Overnight /Express Address
MedMutual Protect	MedMutual Protect
Medicare Supplement Administrative	Medicare Supplement Administrative
PO Box 10863	17757 US Hwy 19 N suite 660
Clearwater, Florida 33757-8863	Clearwater, Florida 33764

Underwriting Office Mailing Information

Mailing Address	Overnight /Express Address
MedMutual Protect	MedMutual Protect
Medicare Supplement Administrative	Medicare Supplement Administrative
PO Box 10862	17757 US Hwy 19 N suite 660
Clearwater, Florida 33757-8862	Clearwater, Florida 33764

Claims Office Mailing Information

Mailing Address	Overnight /Express Address
MedMutual Protect	MedMutual Protect
Medicare Supplement Administrative	Medicare Supplement Administrative
PO Box 10864	17757 US Hwy 19 N suite 660
Clearwater, Florida 33757-8864	Clearwater, Florida 33764

Fax Number for New Business Only

833-522-4876

Fax Number for Underwriting Only

833-522-4878

Forms, General and State Specific

Use the special-order form on StratusAMS to request supplies of forms from MSS. For questions on licensing agents are to contact their manager who will contact the MedMutual Protect licensing team in Oklahoma City.

Phone Numbers

Contact Center	Phone Number
Agent and Customer Support	833-522-4880

Operating Hours

Days of Week	Eastern (ET)
Monday – Thursday	9:00 AM – 6:00 PM
Friday	9:00 AM – 5:00 PM

The specific business areas that are open past 5 PM ET Monday through Thursday for agent, policyholder and provider calls are: New Business, POS (Policyowner Service), Claims and Commission Accounting.

Introduction

The administration of MedMutual Protect Medicare Supplement policies underwritten by MedMutual Life Insurance Company is performed by IAS, a TPA (Third Party Administrator). These administration functions include:

- new business
- function of underwriting
- agent portal
- agent communication
- agent commissions
- production reports
- policyholder fulfillment and delivery requirements,
- premium payments and billing
- policyholder customer service
- conservation

Licensing and ordering forms are handled by MedMutual Protect.

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare Supplement Insurance policies. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. These guidelines represent MedMutual Protect's own independent judgement based on collective experience and review of available data. To ensure we accomplish this goal, the producer or applicant will be contacted directly by underwriting if there are any problems with an application.

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Policy Issue Guideline

All applicants must be covered under Medicare Part A & B. Policy issue is state specific. The applicant's state of residence controls the application, forms, premium, and policy 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 the Required Forms section in this document, for the state specific forms required to submit a MedMutual Protect Medicare Supplement policy in each state.

In all states, an Outline of Coverage and *Guide to Health Insurance for People with Medicare* must be furnished to the applicant at the time of application.

A one-time application fee of $15 is payable at time of application ($6 in Mississippi, no fee allowed in Arkansas or West Virginia).

If the application reflects a replacement of existing Medicare Supplement or Medicare Advantage Plan, a replacement form must be completed and submitted to the Medicare Supplement Administrative Office (MSAO) with the application. Only applicable for paper applications, a second replacement form included with the outline of coverage must be completed and left with applicant.

Open Enrollment

To be eligible for open enrollment, an applicant must be at least 64 ½ years of age and be within six (6) 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.

Medicare Supplement Disability Under 65 State Guidelines As of 8/1/24

State	Requirement to Issue	Plans Required to Issue	When Required to Issue	Rates	Comments
Arizona	No	N/A	N/A	N/A	
Arkansas	Yes	Plan A	N/A	Special disability rate	All these requirements effective 7/01/18
Colorado	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	
Florida	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	
Georgia	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	

State	Requirement to Issue	Plans Required to Issue	When Required to Issue	Rates	Comments
Illinois	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	
Indiana	Yes	Plan A	First six months after Medicare Part B is effective	Special disability rate	
Iowa	No	N/A	N/A	N/A	
Kansas	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Age 65 rate	
Kentucky	Yes	All plans the Company offers	N/A	Special disability rate	Effective 1/1/2024, KY HB 345 requires insurers to offer guaranteed issue coverage to Medicare beneficiaries under 65 who apply within the first six months of their Medicare coverage.
Louisiana	Yes	Filed A, D and GHD	First six months after Medicare Part B is effective	Special disability rate	
Michigan	No	N/A	N/A	N/A	
Mississippi	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	
Missouri	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate OR age 65 rate	MO provides a weighted average formula for calculating the U65 rate. If there is no inforce business, they require using the age 65 rate.
Nebraska	Yes	At least 1 plan, Plan A	N/A	Special disability rate, which can be up to 150% of age 65 rate	Effective 1/1/2025 (NE Legislative Bill 852)
Nevada	No	N/A	N/A	N/A	
New Mexico	No	N/A	N/A	N/A	

State	Requirement to Issue	Plans Required to Issue	When Required to Issue	Rates	Comments
North Carolina	Yes	Plans A, D, and F can be offered based on when an applicant is "newly eligible" for Medicare.	First six months after Medicare Part B is effective	Special disability rate	
Oklahoma	Yes	Plan A	First six months after Medicare Part B is effective	Use Age 65 Preferred Rate	Age 65 rate requirement effective 09/15/17
Pennsylvania	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Age 65 Rate	
South Carolina	No	N/A	N/A	N/A	
South Dakota	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	
Tennessee	Yes	All plans the Company offers	First six months after Medicare Part B is effective	Special disability rate	
Texas	Yes	Plan A	First six months after Medicare Part B is effective	Special disability rate	
Utah	No	N/A	N/A	N/A	
Virginia	Yes	Plan A	Upon the request of the individual during the six-month period beginning with the first month in which the individual is eligible for Medicare by reason of a disability.	Special disability rate	
West Virginia	No	N/A	N/A	N/A	

State	Requirement to Issue	Plans Required to Issue	When Required to Issue	Rates	Comments
Wisconsin	Yes	All riders Company offers	First six months after Medicare Part B is effective.	Special disability rate	
Wyoming	No	N/A	N/A	N/A	

Underwritten Applications

Applicants over the age of 65 and at least six months beyond enrollment in Medicare Part B will be underwritten, provided they do not qualify under a state or federal guarantee issue requirement or state "birthday rule." All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any question(s) is answered "Yes" in the "Health Questions" section, the applicant is not eligible for coverage; do not submit application in these cases.

Application Dates

- Open Enrollment (OE) – Up to six months prior to the month the applicant turns age 65.
    - Wisconsin OE - an application cannot be signed more than 90 days prior to the Part B date.
- Underwritten Cases – Up to 60 days prior to the requested coverage effective date.
- AEP Open Enrollment –Applications are good for 60 days. However, for AEP: We will relax the 60-day sign date to effective date rule. Our current process will allow any application signed in the month of October to have a January 1st effective date.
    - This is for the month of October only.
    - Starting November 1, we will revert back to our normal 60-day application sign date to effective date rule.
    - Do not advise any applicant to disenroll in any coverage until coverage can be verified with underwriting. The applicant has options to ensure continued coverage

Coverage Effective Dates

Coverage will be effective based on rules shown below:

1. Between age 64 ½ and 65 – The first of the month the individual turns age 65. (If birthday is first of the month, Medicare Supplement coverage will be effective first of month prior to birth month.)
2. All others – Application date or date of termination of other coverage, whichever is later.
    - Policies cannot be effective on the 29th, 30th, or 31st of the month due to system billing restraints.

Reinstatement

When a Medicare Supplement policy has lapsed and it is within 90 days of the last paid-to date, coverage may be reinstated, based upon meeting the underwriting requirements. Have client contact customer service at 833-522-4880 to see if they qualify.

When a Medicare Supplement policy 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 policy can be issued.

Policy Delivery Receipt

Delivery receipts are only needed when the policy is mailed to the agent in the following 5 states. The delivery receipt is included with the policy mailed to agent's address on record in StratusAMS. The applicant does not receive notification until IAS completes the second follow up for the delivery requirement. Both the applicant and agent sign delivery receipt and return in envelope provided. If delivery receipt is not returned within 30 days, the policy is converted to a non-taken policy. The premium is returned to the applicant and commissions are charged back.

- Kentucky
- Louisiana
- Nebraska
- South Dakota
- West Virginia

Telephone Interviews

As needed, telephone interviews with applicants will be conducted on underwritten cases.
In Wisconsin, applicants age of 75 and over will have a mandatory PHI. Advise your clients that Underwriting may call to verify the information on their application.

Additionally, an administrative, non-medical telephone interview will be conducted in all cases where the applicant is under age 65 or over age 75 and going on Medicare for the first time. This is to verify demographic and Medicare information only.

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Height and Weight Chart

Use this chart to determine insurability and rate classification of Medicare Supplement applicants who are not eligible for Guaranteed Issue or open enrollment requirements.

HEIGHT		DECLINE	PREFERRED RANGE	STANDARD RANGE	DECLINE
Inches	Feet/Inches	Weight (lbs.)	Weight (lbs.)	Weight (lbs.)	Weight (lbs.)
58"	4'10"	< 72	72-158	159-206	207+
59"	4'11"	< 75	75-163	164-213	214+
60"	5' 0"	< 77	77-169	170-220	221+
61"	5' 1"	< 80	80-175	176-228	229+
62"	5' 2"	< 83	83-180	181-235	236+
63"	5' 3"	< 85	85-186	187-243	244+
64"	5' 4"	< 88	88-192	193-250	251+
65"	5' 5"	< 91	91-198	199-258	259+
66"	5' 6"	< 93	93-204	205-266	267+
67"	5' 7"	< 96	96-211	212-275	276+
68"	5' 8"	< 99	99-217	218-283	284+
69"	5' 9"	<102	102-223	224-291	292+
70"	5'10"	<105	105-230	231-300	301+
71"	5'11"	<108	108-237	238-308	309+
72"	6' 0"	<111	111-243	244-317	318+
73"	6' 1"	<114	114-250	251-326	327+
74"	6' 2"	<117	117-257	258-335	336+
75"	6' 3"	<121	121-264	265-344	345+
76"	6' 4"	<124	124-271	272-353	354+
77"	6' 5"	<127	127-278	279-363	364+
78"	6' 6"	<130	130-286	287-372	373+
79"	6' 7"	<134	134-293	294-382	383+
80"	6' 8"	<137	137-300	301-391	392+

Calculating Premium

Utilize Outline of Coverage

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan/Gender
- Determine if Preferred or Standard rate applies* Subject to the Open enrollment list below
    - Use Preferred rate, if the applicant meets the height and weight requirements listed in underwriting guidelines and answers “no” to the tobacco question on the application.
    - Use Standard rate, if the applicant does not meet height and weight requirements listed in underwriting guidelines **or** answers “yes” to the tobacco question* on the application.
- Find Age - the exact age as of requested effective date or date of application.
- This will be your base monthly premium
    - Modal Factors:
        - Annual = Monthly multiplied by 12
        - Semi-Annual = Monthly multiplied by 6
        - Quarterly = Monthly multiplied by 3

Rate Type Available by State

State	Gender Rates	Attained, Issue or Community Rated	Standard Rates During Open Enrollment	Policy Fee
Arkansas	No	Community	No	$0
Arizona	Yes	Issue	Yes	$15
Colorado	Yes	Attained	No	$15
Florida	Yes	Issue	Yes	$15
Georgia	Yes	Issue	Yes	$15
Illinois	Yes	Attained	No	$15
Indiana	Yes	Attained	Yes	$15
Iowa	Yes	Attained	No	$15
Kansas	Yes	Attained	Yes	$15
Kentucky	Yes	Attained	No	$15
Louisiana	Yes	Attained	No	$15
Michigan	Yes	Attained	No	$0
Mississippi	Yes	Attained	No	$6
Missouri	Yes	Issue	No	$15
Nebraska	Yes	Attained	Yes	$15
Nevada	Yes	Attained	Yes	$15
New Mexico	Yes	Attained	No	$0
North Carolina	Yes	Attained	No	$15
Ohio	Yes	Attained	No	$15
Oklahoma	Yes	Attained	Yes	$15
Pennsylvania	Yes	Attained	No	$15
South Carolina	Yes	Attained	No	$15
South Dakota	Yes	Attained	Yes	$15
Tennessee	Yes	Attained	No	$15
Texas	Yes	Attained	Yes	$15
Utah	Yes	Attained	No	$15
Virginia	Yes	Attained	No	$15
West Virginia	Yes	Attained	Yes	$0
Wisconsin	Yes	Attained	Yes	$15
Wyoming	Yes	Attained	Yes	$15

Health Questions

Unless an application is completed during open enrollment or a Guaranteed Issue period, all health questions, including prescription medications, must be answered. ***An applicant is not eligible for coverage if the answer to any question in this application section is answered "Yes".*** In this scenario, do **NOT** submit an application to MSAO or an eApp.

For a list of uninsurable conditions, please refer to the list below:

Uninsurable Health Conditions

Applications should not be submitted if the applicant has at any time been medically diagnosed with or treated for the following conditions:

AIDS
AIDS Related Complex (ARC)
Alzheimer's Disease
Amyotrophic Lateral Sclerosis (ALS)
Aortic or Cardiac Aneurysm that has not been surgically operated
Cirrhosis
Chronic Hepatitis
Chronic Obstructive Pulmonary Disease (COPD)
Other Chronic Pulmonary Disorders to include:

- Chronic Bronchitis
- Chronic Obstructive Lung Disease (COLD)
- Chronic Interstitial Lung Disease
- Chronic Pulmonary Fibrosis
- Cystic Fibrosis
- Sarcoidosis
- Bronchiectasis

Chronic Kidney Disease or Insufficiency
Crohn's Disease
Dementia
Diabetes if taking insulin to control
Emphysema
Kidney Disease Requiring Dialysis
Multiple Sclerosis
Muscular Dystrophy
Myasthenia Gravis
Organ Transplant or Advisement to have an Organ Transplant (excluding cornea transplant)
Osteoporosis with Fractures
Parkinson's Disease
Positive HIV
Scleroderma
Systemic Lupus

Ulcerative Colitis

Additional Decline Conditions and Scenarios

The following conditions and scenarios will also lead to a decline:

- Use of supplemental oxygen
- Implantable Cardiac Defibrillator
- Bedridden
- Confined to a Wheelchair
- Assistance of a Motorized Mobility Device
- Amputation caused by Disease
- Currently Hospitalized
- In a Nursing Home or Assisted Living Facility
- Been hospitalized two or more times in the past year
- Currently using the services of a Home Healthcare Agency
- Advised by a physician to have surgery (including cataract or joint replacement), medical tests, injections in a physician's office, infusions, or therapy that has not been performed

If the applicant has had any of the following health conditions within the past two (2) years:

- Heart Attack, cardiac angioplasty, bypass surgery, or stent placement/replacement
- Vascular angioplasty, endarterectomy, or implantation of a pacemaker
- Stroke or transient ischemic attack (TIA)

If the applicant has had or been treated for or been advised by a physician to have treatment for the following health conditions within the past two (2) years:

- Alcoholism or drug abuse
- Angina
- Cardiomyopathy
- Coronary Artery Disease
- Carotid Artery Disease
- Congestive Heart Failure
- Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma, Neuropathy, Peripheral Artery Disease
- Peripheral Vascular Disease
- Peripheral Venous Thrombotic Disease
- Any mental or nervous disorder requiring inpatient treatment by a psychiatrist

If the applicant has had or been treated for or been advised by a physician to have treatment for the following health conditions within the past twelve (12) months and:

a.) visited a hospital or urgent care in the last year for one of the conditions **OR**
b.) been prescribed/taken new medication/ increased dosage in medication for any of the conditions
    - Atrial Fibrillation
    - Degenerative Bone Disease

- Heart Valve Disorder
- Heart Rhythm Disorder
- Pancreatitis
- Rheumatoid Arthritis
- Spinal Stenosis

Medication History

All underwritten applications will require a prescription history to be run. The application includes the language for authorization.

Replacements

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

Replacement of a Reserve National Insurance Company or United Insurance Company Medicare Supplement policy to a MedMutual Life Insurance Company Medicare Supplement policy is allowed and agents are required to contact MedMutual Protect's Agency Help Desk to cancel the RNIC policy. Contact the Medicare Supplement Administration office in Clearwater to cancel a UICA policy. All internal replacements will be paid at the current duration. Internal replacements are defined as: An applicant having an RNIC or UICA Medicare Supplement Policy issued within 90 days of the effective date of the new application.

If an applicant has had a MMLIC Medicare Supplement policy issued by the Company within the last 60 days of the effective date of the new application, it will be considered 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 and one copy must accompany the submitted application.

The replacement Medicare Supplement policy cannot be issued in addition to any other existing Medicare Supplement, Select or Medicare Advantage plan.

Household Discount

How to determine eligibility for household discount applicant must currently have a household resident (at least one, no more than three) with whom they have continuously resided for the last 12 months Refer to Household Discount Section #6 on the application.

- If question 1 is answered "Yes", the individual qualifies.

- To calculate a Household discount: Monthly premium multiplied by modal factor = modal premium (round to the nearest whole cent).
- Modal premium multiplied by .93 = discounted premium.

Premium Information

Premiums are calculated based upon the applicant's effective date. Agent/agency checks will not be accepted. Use the exact age, as of the requested coverage effective date.

- Initial Premium
  - The amount determined from the outline of coverage will be the amount you enter on the application for Premium Collected.
  - If applicable, add in policy fee to determine initial payment.
- Premium Payments
  - Payment Modes available are Annual, Semi-Annual, Quarterly or Monthly. Keep in mind Monthly mode is not allowed for direct bill, Bank Draft Only.

Collection of Premium

- Premium may be submitted with the application, drafted upon issue, or drafted upon effective date. Rates are based on effective date of policy.
- If premium is not submitted with the application, we will draft the first month's premium and policy fee upon policy issue/mail date.
- If the applicant would like us to draft premium upon effective date, this needs to be notated on the application or electronic authorization form.
- Credit Card payments are not available.
- 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.

Business Checks

Business checks are acceptable if they are submitted for the business owner or the owner's spouse. Foundation checks will not be accepted.

Premium Receipt and Notice of Information Practices

Leave the Premium Receipt and the Notice of Information Practices with the applicant. The Premium Receipt must be completed when provided to applicant if premium is collected.
NOTE: Do not mail a copy of the receipt with the application.

Shortages

Depending on the mode of premium collected, the company will do one of the following.

- Initial payment via Check – request balance as a delivery requirement.
- Bank Draft – agent is contacted to have amount corrected on application or bank draft form.

- Or if telephone interview takes place and correct amount can be confirmed with applicant, correct premium will be drafted.

Refunds

In the event of decline, incomplete submission, overpayment, cancellations, etc., the Company processes refund via check, after 7 business days has elapsed. If the check is greater than $1000.00, we will hold the check for 21 days.

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.

Guaranteed Issue Rules

State specific Guaranteed Issue or special enrollment scenarios, including birthday rules along with plan availability can be found on the portal under agent documents in the state forms section. To access the portal please log into: https://service.iasadmin.com/medmutual

Medicare Advantage (MA)

Medicare Advantage (MA) Annual Election Period

General Election Periods for Medicare Advantage (MA)	Timeframe	Allows for…
Annual Election Period (AEP)	Oct. 15th – Dec. 7th of every year	• Enrollment selection for a MA plan • Disenroll from a current MA plan • Enrollment selection for Medicare Part D
Medicare Advantage Disenrollment Period (MADP)	Jan. 1st – Mar. 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 MADP 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 SHIP office for direction.

Medicare Advantage (MA) Proof of Disenrollment

Proof of MA disenrollment will no longer be required, provided the termination date of the MA plan does not overlap the effective date of our policy, except in these circumstances:

- Underage individuals that are turning 65 and moving from MA to Medicare Supplement.
- Underwriting cannot issue coverage without proof of a Guaranteed Issue qualifying event.

Disenroll during AEP and MADP

Complete the MA section on the Medicare Supplement application; we require one of the following when applicant is disenrolling from Medicare Advantage plan.

1. The applicant submits a disenrollment letter, if replacing a Medicare Advantage plan.
2. The applicant submits screenshots of their disenrollment status on Medicare.gov. Agents should not advise in disenrollment of MA Plans, without confirmation of underwriting coverage approval. Underwriting will contact the agent via agent portal message and advise that the applicant qualifies medically and ask the agent to assist or let the applicant know to start the disenrollment process.

If an individual is disenrolling outside AEP/MADP

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 (SHIP) 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.

Application

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

- All sections are completed
- Agent Writing Number
- Applicant has signed application

Applicant Information Section

- 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 provide in box next to resident address on application.
- Age and Date of Birth are the exact age as of the application date. Rates will be based on applicant's age on the policies effective date.
- Height/Weight —Are required on all underwritten cases.

- Social Security and Medicare Number are required in order to set up for Electronic Crossover from Medicare. Medicare Claim number, also referred to as the Medicare Beneficiary Identifier (MBI) number, is vital for electronic claims payment.
- Please indicate dates enrolled for both Medicare Part A and B and if they enrolled in Part B more than once.

Plan Information Section

- Entire Section must be completed.
- This section should indicate the plan or policy form selected, requested effective date and the policy premium method and modes.
  Coverage will be effective based on rules shown below:
  1. Between age 64 ½ and 65 – The first of the month the individual turns age 65. (If birthday is first of the month, Medicare Supplement coverage will be effective first of month prior to birth month.)
  2. All others – Application date or date of termination of other coverage, whichever is later.
- Policies cannot be effective on the 29th, 30th, or 31st of the month due to system billing restraints.
- 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.

Eligibility Information Section

- If applicable answer tobacco related questions.
- If applying and are eligible for Medicare due to Disability or End Stage Renal Disease (ESRD), the entire Section must be completed.
- If the applicant is applying during a Guaranteed Issue period, be sure to include proof of eligibility.

Health Information Section

- If the applicant is applying during an open enrollment or a Guaranteed Issue period, do not answer the health questions, and go to “Replacement Questions” section of application.
- If applicant is not considered to be in open enrollment or a Guaranteed Issue situation, all health questions must be answered.

NOTE: In order to be considered eligible for coverage, questions 1-9 and subsequent questions in health questions must be answered “No.” Question 8 is an automatic decline if subsequent questions (a or b) are “Yes”. For questions on how to answer a particular health question, see the Health Questions section of this Guide for clarification.

Replacement Information Section

- If applying for replacement policy, entire Section must be completed.

- If the applicant qualifies for Guarantee Issue, be sure to include proof of eligibility or notice from prior carrier.

Household Discount Information Section

- If question is answered "Yes", the individual may qualify.
- If applicant qualifies for Household Discount: calculate the Household Discount by: multiplying monthly premium by modal factor = modal premium (round to the nearest whole cent)
- Modal premium multiplied by .93 = household discounted premium

Other Policies Information Section

- Be sure to list all policies you have sold to applicant.
- List in force and lapse in proper sections.

Applicant Statement Section

- Ensure the applicant reads section completely.

Electronic and/or Telephonic Section

- If applicant would like information over phone, they must authorize in first section.
- If applicant would like information via internet, they must authorize in second section.
- Applicant can authorize one, both or neither section. Electronic delivery of the policy is only offered on applications taken via the eApp.

Agreement and Authorization Section

- Applicant acknowledges receiving the Guide to Health Insurance and Outline of Coverage. It is required to leave these two documents with the client at the time the application is completed.
- Applicant agrees to the Authorization to Disclose Personal Information.
- Signatures and dates: required by applicant(s).
- POA is only allowed for applicant's applying during Open Enrollment or Guaranteed Issue scenario. 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 correct manner for the individual holding a Power of Attorney on the applicant is, for example: "John Smith, under Power of Attorney for Jane Doe."

Agent Certification Section

- Signatures and dates: required by producer.
- The producer must be appointed in the applicant's resident state and the state where the application is signed.
- The producer(s) must certify that they have:

- provided the applicant with a copy of the replacement notice if applicable,
- accurately recorded in the application the information supplied by the applicant,
- and have interviewed the proposed applicant.