"Serving you
-since '32"

OLD SURETY LIFE
INSURANCE COMPANY
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MEDICARE SUPPLEMENT UNDERWRITING GUIDELINES

Please review this guide BEFORE presenting proposals and submitting applications. The purpose of this guide is to provide agents with the basic information needed to market **OLD SURETY LIFE INSURANCE COMPANY'S** Medicare Supplement coverage. While we have made every effort to make this information as accurate as possible, it should only be used as a guide to help agents to field underwrite potential applicants for **OLD SURETY LIFE INSURANCE COMPANY'S** Medicare Supplement plans.
Please remember that no agent has the authority to change any benefits to bind coverage with OLD SURETY LIFE INSURANCE COMPANY or to promise a certain effective date.

OLD SURETY'S PHILOSOPHY

We seek to insure individuals in good health who want quality products and excellent service. By working together with the agent, we believe we can generate a good block of business that will maintain a favorable loss ratio and thereby keep the rates affordable.

It is the agent's responsibility and duty to obtain accurate and complete information asked in each question on the application. It is the agent's obligation to the applicant to review all questions and related answers. Care on the part of the agent saves time, expense, misunderstanding and litigation.

Guidelines For Potential Applicants

Premium Rates are based on client's age on Date of issue(Effective Date) of a policy, not age at date of application.

HOUSEHOLD DISCOUNT (not applicable in all states, check rate sheet in specific state for availability)

How to determine eligibility for household discount

*****Refer to Household Discount Section on the application
*****If question #1 or #2 is answered "Yes", the individual qualifies

The Household discount is available to:

*Individual who has resided, for at least one year, with a living person over the age of 18, or an individual who is married residing together regardless of length of time. The other individual does not have to be an Old Surety policyholder.

Policy Conversions

Policy Conversions are considered to be a current policyholder submitting an application for a "New Policy".
In order to be considered for a policy conversion, the following conditions must apply

1. Applicant must have had current policy with Old Surety for a minimum of 23 continuous months *(Conversions will not be considered before 2nd policy Anniversary date)*
2. Rate will be based on age of applicant on the Effective date of the "new" policy. Applicant will be required to submit a new application, and will be underwritten based on the new application and underwriting information obtained during the application process.
3. Applicant can have no lapse in coverage for policy to be considered for a Conversion
4. If an applicant wishes to change rate class, due to non tobacco use in past 2 years, proof of tobacco cessation must be available through an APS from a physician. They will be considered the same as a Conversion and will be subject to those same guidelines.

These guidelines are intended to help the agent avoid solicitation of applicants who cannot qualify for this insurance. There are many conditions or circumstances for which we cannot provide a policy because of the increased risk to the Company. However, if the agent believes that the circumstances are unusual and deserve special consideration, an application may be submitted with details on a separate sheet of paper and supplied with the application.

Tips for Completing an Application:

Always ask each question exactly as it is written on the application, and complete all the information on the Application and the related forms.
Always record each answer exactly as it is given.
Always furnish complete information on the Application:

1. Treatment's that were received
2. Dates of treatment
3. Name, Address and Telephone number of each individual physician.

If beneficiary is in their Open Enrollment period or qualifies for Guarantee Issue this information cannot be used to deny or refuse them coverage. It is for statistical and actuarial information only. If beneficiary is in their Open Enrollment period and does not have Creditable Coverage, please follow guidelines below that refer to Pre-Existing Conditions.

Always **complete the application legibly and in black ink.**

Always have each applicant initial and date any correction or mistake.

Always have the application signed by the applicant and yourself (do not print names for signatures). Power of Attorney signatures and signatures of spouses are not permitted.

Never tell or suggest to the applicant how he or she should answer a question.

Never leave out any details of an applicant's answer; it may be helpful to issue the policy.

Never ask a general question such as "Are you in good health", and then answer all the health questions no.

Never complete an application by telephone or correspondence. You must be present at the time of the Application and personally witness the applicant's signature.

*****Careful questioning of the applicant is very important in developing medical history. **Only the Underwriting Department can make the final decision**; therefore, ***never*** suggest or promise that a policy will be issued.
***NEVER suggest an applicant should drop their current coverage until their policy with us is issued!**

Incomplete Applications or Supporting Documentation
If there is insufficient information on the application, or if an applicant is applying during an Open Enrollment or a Guarantee Issue scenario where supporting documentation is required, we will contact the agent during the application process to obtain information. If information is not received within 60 days of the application date, the application may be terminated as incomplete and a letter sent to the applicant and agent. Any refund of premium will be returned to the applicant.

To expedite the underwriting process, the agent needs to provide:

- ***** Full names and addresses of the doctors seen.
- ***** Diagnoses of all impairments.
- ***** Results of all tests, if known.
- ***** Dates of initial diagnosis and treatment dates since.
- ***** Names of all prescription drugs and doses, if known.
- ***** If recurring symptoms, date of first and last episode and average number of occurrences per year.

Pre-Existing Restrictions:

Pre-existing restrictions apply ONLY during "Open Enrollment" if the applicant does NOT have creditable coverage: therefore, be sure to include the applicant's prior coverage information on the application. You will also need to include proof of this coverage with the application when you submit it. Coverage for a pre-existing condition can only be excluded in a Medigap policy if the condition was treated or diagnosed within the 6 (six) months before the effective date of the Medigap policy. The pre-existing condition(s) may not be covered for the first 6 (six) months of the Medigap policy. Beneficiaries in their Open Enrollment period cannot be denied coverage even if they have pre-existing conditions and no creditable coverage. Original Medicare will still cover their condition(s) even if the Medigap policy won't cover the beneficiaries out of pocket expenses.

Home Office Underwriting Procedures

Step 1 Upon receipt of a Medicare Supplement application, Home Office personnel will verify the contents of the application by telephone. This "double check" is designed to protect the agent and the Company as well as answer any questions the applicant may have had since the time of application.

Step 2 Most Medicare Supplement applications are underwritten from the application, however the Company reserves the right to request additional medical data for any application from an applicant or an applicant's physician. Unfortunately, when additional medical information in necessary, there will be a delay in making a decision. Such cases normally remain in the Home Office for 10 to 15 working days. We will do everything possible to hold these situations and delays to a minimum. Your help and cooperation will be appreciated.

If additional medical information is needed, Underwriting will advise the agent.

Step 3 Issued policies are mailed to the agent for delivery, unless the agent has requested otherwise. Notification of declined applications and refunds are mailed directly to the applicant, with a copy sent to the agent.

Please be aware that the Company will not discuss with the agent or the applicant, specific medical information which led to any underwriting decisions. If the applicant desires specific medical information, the Company will, upon written request from the applicant, disclose our reasons to the policyholder, or the physician from whom the records were obtained, who then in turn can disclose the information to their patient if they so desire.

This following list cannot be all-inclusive but is intended to be a general guideline that will apply in most all cases. The list is subject to periodic revision by the Underwriting Department. ***REMEMBER;*** the fact that certain impairment is not listed on the application, or on the Uninsurable List, does not mean that it is insurable.

If the agent has questions regarding specific medical conditions, which may deserve special consideration, he or she may call and discuss the matter with the Underwriting Department prior to submission of the application. Any representations made by individuals in the Home Office will be based upon the information provided in the call and are not to be taken as guarantees.

Applications will be underwritten based on the information from the application, telephone interview, and if requested, an APS report. : An APS may be requested notwithstanding instances when APS will always be required.

DO NOT SUBMIT AN APPLICATION IF THE APPLICIANT:

Exception : If an applicant is in their Open Enrollment or a Guarantee Issue Scenario

- Is not covered by Medicare Parts A and B.
- Is covered by Medicaid.
- Is confined in a Hospital or Nursing Facility.
- Is confined to a wheelchair. (except for Disability Medicare Supplement which may be considered on a case by case basis)
- Has been advised to have ***any*** type of surgery (ex. Cataracts, Joint Replacement, Heart, Vascular, etc..)
- Has been advised or is contemplating a Hospital or Nursing Facility confinement.
- Has been hospitalized more than one time in the past two (2) years. (Depending on reasons for stays may be considered on case by case basis)
- Has had surgery and has not yet been released from doctor
- Has a Pacemaker
- Has only one (1) Kidney
- Has received an organ transplant.
- Has an inoperable heart disorder.
- Is covered under another Medicare Supplement plan which they are not replacing.
- Is retaining any health plan that duplicates benefits provided by Medicare.
- Has any of the impairments listed on the Uninsurable Impairments list.

Medicare Advantage (MA) Proof of Disenrollment

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

Disenrolling from MA plan at anytime during the year

Complete the MA section on the application; and

1. Send ONE of the following with the application
    a. A copy of the applicant's request to cancel the MA plan they are currently enrolled in
    b. A copy of the applicant's MA plan's termination notice

Old Surety's Policy on individuals losing or dropping their group coverage:

The Affordable Care Act has affected many Group and Employer Sponsored Health Plans. Old Surety is seeing an increase in individuals on Medicare losing or having to change their Group or Employer Sponsored Health Plans. We are also seeing some confusion with what does or does not trigger an individual's rights to Guaranteed Issue.

Old Surety wants to clarify its policy on how Federal and State laws determine an individual Guaranteed Issue Rights:

GUARANTEEISSUE RULES

The rules listed below are the Federal requirements. These rules can also be found in the Centers for Medicare & Medicaid Services (CMS) annual publication, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

Guarantee Issue Situation	***Client has the right to:***
Client is in the original Medicare plan 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: State laws may vary in this situation.*	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered). If the client has COBRA coverage, the client must wait until the COBRA coverage ends.
Client is in the original Medicare plan and has a Medicare SELECT policy. The client moves out of the Medicare SELECT plan's service area. Client can keep their Medigap policy or he/she may want to switch to another Medigap policy.	Medigap Plan A, B, C, F, K or L that is sold by any insurance company in the client's state or the state he/she is moving to, (if plan is offered).
The client's Medigap insurance company goes bankrupt, and the client loses coverage; or, the client's Medigap policy coverage otherwise ends through no fault of the client.	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered).

GUARANTEEISSUE RIGHTS

Guarantee Issue Situation	***Client has the right to:***
The client's Medicare Advantage plan is leaving the Medicare program, stops giving coverage in his/her area, or the client moves out of the plan's service area.	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered). The client must switch back to original Medicare.
The client joined a Medicare Advantage plan when first eligible for Medicare Part A at age 65, and within the first year of joining, the client decided to switch back to original Medicare.	Buy any Medigap plan that is sold in your state by any insurance company, (if plan is offered).
The client dropped his/her Medigap policy to join a Medicare Advantage plan for the first time, has been in the plan for less than one year, and wants to switch back to original Medicare.	Obtain the client's former Medigap policy back if that carrier still sells it. If the former Medigap policy is not available, the client can buy a Medigap Plan A, B, C, F, K or L that is sold in his/her state by any insurance company, (if plan is offered).
Client leaves a Medicare Advantage plan because the company has not followed the rules or has misled the client.	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered).

Please note that applicants may apply up to 60 calendar days prior to the date the coverage will end and ***MUST*** *apply no later than 63 days after the coverage ends.*

Group Health Plan Proof of Termination

Proof of Involuntary Termination:
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, a copy of the I.D. card for the applicant's current coverage and a letter stating the date coverage will be ending will be required if not completed on the application.

Guarantee Issue Rights for Voluntary Termination of Group Health Plan:

State Specific Rules	*Guarantee Issue Situation:*	*Client has the right to:*
CO,MT,TX	Client is voluntarily leaving their group health plan and the employer sponsored plan is primary to Medicare.	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered).
NM, OK *See Note	Client is voluntarily leaving their group health plan and the Employer sponsored plan's benefits are reduced substantially.	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered).
AR, KS, MO	Client is voluntarily leaving their group health plan: No conditions – always qualifies	Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company, (if plan is offered).

*NM and OK
For purposes of determining GI 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 co-pays or coinsurance %). A premium increase without an increase in the deductible or coinsurance requirement will not qualify for GI eligibility.

If a beneficiary is planning to voluntarily drop or disenroll from their current Group or Employer Sponsored Health Plan in the following states (CO, TX, AR, KS, MT and MO) and apply for a Medicare Supplement with Old Surety, Old Surety will process the application as a Guarantee Issue.

If a beneficiary plans to keep their current Group or Employer Sponsored Health Plan and apply for a Medicare Supplement with Old Surety, documentation of continuation of coverage must be submitted, if documentation is not provided the application will be processed as a Guarantee Issue.

Please refer to your contract to determine what commissions or fees are applicable when a policy is issued based on Guarantee Issued Rights.

UNINSURABLE IMPARIMENTS

- Acquired Immune Deficiency Syndrome (AIDS)
- Addison's Disease
- Alcoholism
- Alzheimer's Disease
- Amputation caused by disease
- Angina Pectoris, if diagnosed within six (6) months or if frequent nitroglycerin is required
- Internal Cancer (including Melanoma) if currently present, treated by surgery within past two (2) years, treated by radiation or chemotherapy within past five (5) years. *(APS will be requested if history of cancer within last 10 yrs)
- Cardiomyopathy
- Chronic Brain Syndrome
- Cirrhosis of the liver
- COPD
- Heart Attack, Coronary Bypass Surgery, Angioplasty and or Stent Placement within past two (2) years *(APS will be requested if a history of Heart Attack or Bypass)
- Crohn's Disease / Ulcerative Colitis / Regional Enteritis, if severe
- Cushing's Syndrome
- Congestive heart failure within past six (6) months
- Diabetes requiring Insulin *(Diabetes with oral medications will be considered and an APS will be requested)
- Emphysema and or Lung Disorder requiring Oxygen
- Hemophilia
- Hodgkin's Disease
- Kidney Dialysis
- Leukemia
- Lou Gehrig's Disease
- Lupus (disseminated or systemic)
- Multiple Sclerosis
- Muscular Dystrophy
- Osteoporosis, if severe or disabling
- Paget's Disease
- Parkinson's Disease (individual consideration)
- Psychosis (insanity)
- Rheumatoid arthritis (individual consideration)
- Stroke within past (2) years or more than one (1) in five (5) year period
- **Applicant MUST have verifiable Medical information within past 24 months (must have seen a Doctor within past 24 months)**
- **Tobacco use of any kind within past 2 years should be quoted Tobacco rates**

*APS is the Attending Physician Statement by whom the condition(s) are treated

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Old Surety Rate Type Available by State

State	Tobacco/Non-Tobacco Rates	Gender Rates	Tobacco Rates During Open Enrollment/Guarantee Issue	Household Discount
AR	**Y**	**N**	**N**	**N**
CO	**Y**	**Y**	**N**	**N**
KS	**Y**	**Y**	**Y**	**N**
MO	**Y**	**Y**	**N**	**N**
MT	**Y**	**N**	**Y**	**N**
NC	**Y**	**Y**	**N**	**N**
NM	**Y**	**Y**	**Y**	**N**
OK	**Y**	**Y**	**Y**	**N**
TX	**Y**	**Y**	**Y**	**Y**