CENTRAL STATES INDEMNITY
A Berkshire Hathaway Company

CENTRAL STATES INDEMNITY CO. OF OMAHA
Home Office: Omaha, NE
Administration: P.O. Box 10816
Clearwater, Florida 33757-8816

APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE

SECTION A. PROPOSED INSURED INFORMATION

Applicant Name *(exactly as it appears on your Medicare card)*	
Resident Address	Phone *(with area code)*
City	State, Zip Code
Date of Birth *mm/dd/yyyy*	Current Age
Male ☐ Female ☐	Social Security No
Medicare Card No	
Email Address	
Height *Feet and inches*	Weight *Pounds*

SECTION B. PLAN AND PREMIUM INFORMATION

Plan	Requested Policy Effective Date	Household Premium Discount Yes ☐ No ☐ *If you answered Yes, please complete the Household Discount form.*	
Premium $		Policy Fee $	
Premium Collected $		Initial Bank Draft: $	Issue Date ☐ Effective Date ☐
Payment Mode:	Monthly ☐ (Bank Draft or Credit Card ONLY)	Annual ☐	Semi-Annual ☐ Quarterly ☐
Payment Method:	Bank Draft ☐	Credit Card ☐	Direct Bill ☐

SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Have you used tobacco in any form in the past 12 months?	Yes ☐ No ☐
2. Are you covered under Medicare Part A?	Yes ☐ No ☐
If NO, what is your future Part A effective date? ___/___/___	
If YES, what is your Part A effective date? ___/___/___	
3. Are you covered under Medicare Part B?	Yes ☐ No ☐
If NO, what is your future Part B effective date? ___/___/___	
If YES, what is your Part B effective date? ___/___/___	
Is this your first time enrolling in Medicare Part B?	Yes ☐ No ☐
4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility).	Yes ☐ No ☐
5. Are you eligible for Medicare due to Disability or End Stage Renal Disease (ESRD)?	Yes ☐ No ☐
IF YES, please check the box that applies. ☐ Disability ☐ End Stage Renal Disease (ESRD)	

SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION F.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1 - 12, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or require the use of a wheelchair or motorized mobility aid, or have you had any amputation caused by disease?	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD), Sarcoidosis, Scleroderma, or other chronic pulmonary disorders?	Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis, Hepatitis C or kidney disease?	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	Yes ☐ No ☐
6. **If you have diabetes**, do you have any of the following conditions: peripheral vascular disease, any heart condition or kidney disease? If you do **not** have diabetes, this question should be answered "NO."	Yes ☐ No ☐
7. Have you ever had a medical professional advise you to take more than 50 units of insulin daily or have you ever required more than 50 units of insulin daily for diabetes?	Yes ☐ No ☐
8. Within the past three years have you had or been treated for or been advised by a physician to have treatment for internal cancer, malignant melanoma, ulcerative colitis, Crohn's disease, alcoholism or drug abuse, or have you been advised to have a joint replacement?	Yes ☐ No ☐
9. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts?	Yes ☐ No ☐
10. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐
11. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐
12. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐

SECTION D. HEALTH QUESTIONS (continued)

If you answer YES to any of the following health questions 13 – 16, you may be eligible for coverage.

13. Within the past two years have you had or been treated for or been advised by a physician to have treatment for heart attack, heart disease, heart valve disease, coronary artery disease, carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure, enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes ☐ No ☐

14. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis? Yes ☐ No ☐

15. Within the past two years have you had or been treated for or been advised by a physician to have treatment for a mental or nervous disorder requiring psychiatric care? Yes ☐ No ☐

16. If you have diabetes, do you have diabetic retinopathy, neuropathy or high blood pressure? Yes ☐ No ☐

(Please explain any yes answers to questions 13 - 16 below)

SECTION E. MEDICATION HISTORY

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? Yes ☐ No ☐

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	
Medication Name (copy off pharmacy label)	
Date **Originally** Prescribed	
Dosage and Frequency	
Diagnosis/Condition	

SECTION F. REPLACEMENT QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes ☐ No ☐
   (b) Did you enroll in Medicare Part B in the last six months? Yes ☐ No ☐
   (c) If YES, indicate your effective date. / /

2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐
   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)
   If YES, answer (a) – (b) below.
   (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐
   (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.) Yes ☐ No ☐
   If YES, answer (a) – (g) below.
   (a) Name of Company _____
   Plan Type & Policy/Certificate No _____
   Company Telephone Number _____
   Coverage Dates: START DATE / /
   (if you are still covered under this plan, leave end date blank) END DATE / /
   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes ☐ No ☐
   If YES, have you received a copy of the replacement notice? Yes ☐ No ☐
   (c) Reason for termination/disenrollment? _____
   (d) Planned date of termination/disenrollment? / /
   (e) Was this your first time in this type of Medicare plan? Yes ☐ No ☐
   (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐
   (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes ☐ No ☐
   If YES, answer (a) – (d) below.
   (a) Name of Company _____
   Plan Type & Policy/Certificate No _____
   Company Telephone Number _____
   Issue Date / /
   (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐
   (c) Indicate termination date. / /
   (d) Have you received a copy of the replacement notice? Yes ☐ No ☐

SECTION F. (continued)

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐

If YES, answer (a) – (c) below.

(a) Name of Company

Plan Type & Policy/Certificate No

Company Telephone Number

Coverage Dates: START DATE / /

(if you are still covered under this plan, leave end date blank) END DATE / /

(b) Reason for termination/disenrollment?

(c) Planned date of termination/disenrollment? / /

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

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

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

Name of Company

Policy/Certificate Number

Description of Benefits

Effective Date of Coverage

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstituted, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Central States Indemnity Co. of Omaha, or its reinsurers, any such information. I understand that I am authorizing Central States Indemnity Co. of Omaha to receive my health information and prescription drug usage history. The released information received by Central States Indemnity Co. of Omaha will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Central States Indemnity Co. of Omaha. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Central States Indemnity Co. of Omaha *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Central States Indemnity Co. of Omaha in writing at their Medicare Supplement Administrative Office: P.O. Box 10816, Clearwater, Florida 33757-8816. I understand that such revocation will not have any effect on actions Central States Indemnity Co. of Omaha took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "*Guide to Health Insurance for People with Medicare*."

Signed at:	_____	_____	_____
	State	Applicant's Signature	Date
Signed at:	_____	_____	_____
	State	Agent's Signature and Writing Number	Date

Policy Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant

IMPORTANT NOTICE ABOUT THE POLICY OF INSURANCE FOR WHICH YOU HAVE APPLIED

THIS AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY.

1. The policy for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any dispute related to this policy must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and Central States Indemnity Co. of Omaha.
4. In an arbitration, one or more arbitrators, who are independent, neutral decision makers, render a decision after hearing the positions of the parties.
5. When you accept this insurance policy you agree to resolve any dispute related to the policy by binding arbitration instead of a trial in court, including a trial by jury.
6. Binding arbitration generally takes the place of resolving disputes by a judge or jury.
7. Should you need additional information regarding the binding arbitration provision in the policy, you may contact our toll free assistance line at 855-664-5517.

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any dispute between Central States Indemnity Co. of Omaha and myself resolved in court. This means I am waiving my right to a trial by jury.

I understand that upon receipt of the policy, I should read the arbitration clause contained in the policy and that I have the right to reject this policy within thirty (30) days of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that failure to sign this Acknowledgement will result in the rejection of the Medicare Supplement Insurance Policy coverage.

I understand that this same type of insurance may be available through an insurance company that does not require that policy related disputes be resolved by binding arbitration.

Applicant's Signature	**Date**
Agent's Signature	**Date**

CENTRAL STATES INDEMNITY CO. OF OMAHA

Home Office: Omaha, NE
Administration: P.O. Box 10816
Clearwater, Florida 33757-8816

Medicare Supplement Household Discount Form

Applicant Name:	Applicant Social Security Number:

To qualify for the Household discount, the applicant must meet one of the following criteria below. Please select the box which applies:

- ☐ I am currently married and residing with my spouse named below.
- ☐ I have been residing with the person named below who is age 50 or older for at least the last 12 months.

Spouse or Additional Resident Name:			
Address:	City:	State:	Zip Code:
Last Four Digits of Social Security Number:		Date of Birth(mm/dd/yyyy):	
Relationship to Applicant:			

If the spouse/additional resident named above currently has a Central States Indemnity Medicare Supplement policy (Policy #_____) the discount will be applied to this policy also.

Agent/Applicant Signature:

By signing this form I certify that I qualify for the household discount by meeting the criteria listed above.

Agent's Signature Date

Applicant's Signature Date