

Sign In

**PROSPERITY**<sup>SM</sup>  
CONTRACTING

SBLI USA Life Insurance Company, Inc.  
S.USA Life Insurance Company, Inc.

Enter your email address to get started...

Enter your email address

Email Address

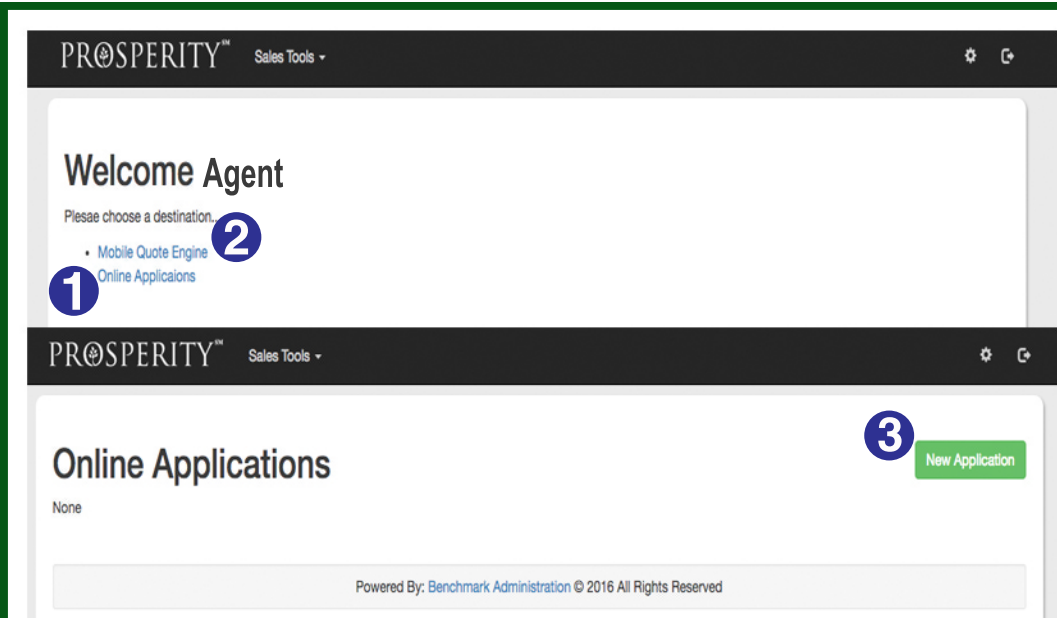
Go

BENCHMARK

**Let's get started! Go to [www.prosperitycontracting.com](http://www.prosperitycontracting.com)**

1. Username: Email address
2. Password: (you created this during the contracting process)

Forgot your login credentials, contact us @ 855-321-2755

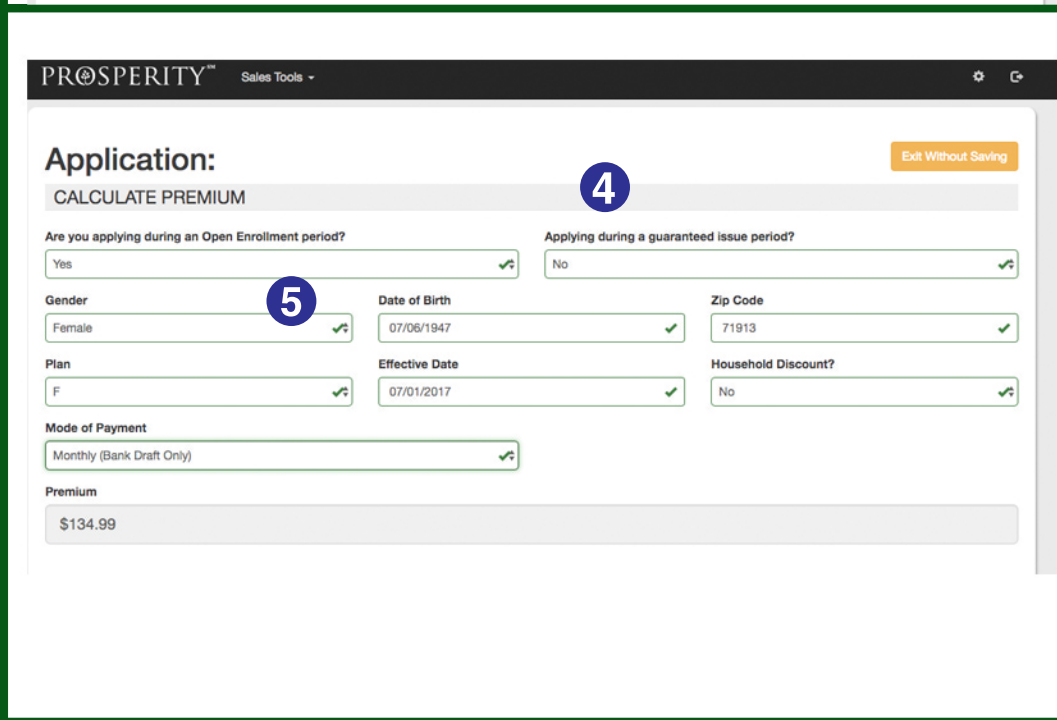


**1** Click on Online Applications, to launch Medicare Supplement eApp tool from prosperitycontracting.com

**2** You can quote the rate before starting e-App by using mobile quote engine

**3** Start New Application  
Medicare Supplement eApp tool is supported for following browser and device,

- Microsoft® Internet Explorer (8, 9, 10)
- Firefox (for Windows)
- Apple® Safari® (for Mac and iPad)
- Google® Chrome® (for Windows)



**This tool is part of a “live” system. Therefore, please do not “submit to carrier” test applications as they WILL be processed.**

**4** Choose applicant’s enrollment period for which they are applying.

**5** Enter applicant’s gender, date of birth, plan which applying for, effective date of policy, and mode of payment.

This section is also where you will select if the applicant qualifies for a Household Discount.

To qualify for the Household Discount, the applicant must meet one of the following criteria:

- \* Currently residing in a Household with legal spouse
- \* Currently residing in a Household with a person who is age 18 or older for at least the last 12 months

*\* RULES VARY BY STATE-PLEASE CHECK THE UNDERWRITING GUIDE FOR RULES*

**SECTION 1: APPLICANT INFORMATION** 6

First Name: Jane ✓ Middle Name: L Last Name: Doe ✓

Residence Address: 145 Sunshine Road ✓ City: Royal ✓ State: AR

Home Phone: 501-623-3506 ✓

Social Security No: 123-45-6789 ✓ Medicare Number (or MBI Number): 123456789a ✓

Height: Feet: 5 ✓ Inches: 5 ✓ Weight in Pounds: 120 ✓

1 2 3 4 5 6 7 8 9 7 Section 2→

**6** Enter Applicant's demographic information- DOB, Address, SSN. Height and weight.  
Note: Agent must be appointed in all states in which they wish to take a application. The state will not appear in the drop down menu if the agent is not appointed.

**7** Required fields should be filled before completing application. If required fields are incomplete, then the section will be highlighted in red with-✗  
Once required field is complete, field is marked with ✓

CLICK MOVE TO SECTION 2

**PROSPERITY™** Sales Tools -

**Application: Jane Doe** Exit Without Saving

**SECTION 2: PLAN / PREMIUM PAYMENT INFORMATION**

Premium: 125.54 8 Policy Fee: 0.00

Premium Collected: 0.00 Initial Bank Draft: 125.54 Method of Payment: Bank Draft

**Electronic Fund Transfer Information**

Indicate below when you would like your account drafted.  
Many of our customers have requested the option to pay their premiums on the same day they receive Social Security or SSI payments. The options below allow you to select the date that best fits your needs. You may select any option regardless of whether or not you receive Social Security.

Initial Premium Payment: On the Policy Issue Date ✓ 9

Subsequent Premium Payments: 1st day of the Month ✓

NOTE: If one of the above dates falls on a weekend or holiday, deduction will be on prior business day.

**8** This section is where the premium payment information is figured. Policy fees will be automatically calculated based on the state.

**9** Initial Premium Payment and Subsequent Premium payment information. Select based on applicant's preferences.

**Medicare Supplement Household Discount Form** 10

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

I am currently residing in a Household\* with my legal spouse named below. ✓

\*Household is defined as a condominium unit, a single family home, or an apartment unit within an apartment complex. Assisted Living Facilities, Group Homes, Adult Day Care facilities and Nursing Homes, or any other health residential facilities are not included in the definition of Household.

Legal Spouse or Additional Resident Name:  ✓ Relationship to Applicant:  ✓

Last Four Digits of Social Security Number:  ✓ Date of Birth:  ✓

If the legal spouse/additional resident named above currently has a S.USA or SBLI Medicare Supplement policy the discount will be applied to this policy also.

Legal Spouse or Additional Resident Policy Number:

I certify that the applicant qualifies for the household discount by meeting the criteria listed above.  ✓

← Section 1      1 2 3 4 5 6 7 8 9      Section 3→

**10** House Hold Discount form: This form is required if the applicant is applying for a House Hold discount. Enter household member demographics- Name, relationship to applicant, last 4 of SSN, DOB.

**THIS PAGE SHOULD ONLY APPEAR IF HOUSEHOLD DISCOUNT WAS MARKED "YES" IN SECTION 1 OF THE APPLICATION.**

**Application: Jane Doe** Exit Without Saving

**SECTION 3: MEDICARE INFORMATION** 11

Are you covered under Medicare Part A?  ✓ Part A effective/eligibility date:  ✓

Are you covered under Medicare Part B?  ✓ Part B effective date (or date you plan to enroll):  ✓

First time enrolling in Medicare Part B?  ✓ Will you turn 65 within the next six months?  ✓

Eligible for Medicare due to Disability or ESRD?  ✓ Replacing Creditable Coverage?  ✓

If you do not have six months of Creditable Coverage, any health condition for which medical advice or treatment was recommended by a medical professional or received from a medical professional within a (6) month period preceding the Effective date of the coverage you have applied for is subject to the Pre-Existing Condition limitation. Please list those medical conditions in the space provided below.

**11** Medicare Information- application type- open enrollment (OE), guaranteed issue (GI), Underwritten (UW) are determined based on the response provided to the medicare information.

**Application: Jane Doe** Exit Without Saving

**SECTION 4: MEDICAL QUESTIONS** 12

If you answer Yes to any of the following questions, you are not eligible for coverage.

Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home health care; or, are you bedridden or require the use of a wheelchair or motorized mobility aid?  ✓

Have you been diagnosed with or treated for emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?  ✓

**12** Medical questions: if applicant is applying during either open enrollment (OE) or guaranteed issue (GI) period then medical questions will not appear.

**PROSPERITY** Sales Tools

Application: Jane Doe Exit Without Saving

**SECTION 9: AUTHORIZATION – PLEASE READ AND SIGN BELOW** 13

How would you like this application to be signed? Verbal Authorization

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, 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 provide to S.USA LIFE INSURANCE COMPANY, INC., or its reinsurers, any such information. I understand that I am authorizing S.USA LIFE INSURANCE COMPANY, INC. to receive my health information and prescription drug usage history. The released information received by S.USA LIFE INSURANCE COMPANY, INC. 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.

Do you agree? Yes

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 insurance; 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 S.USA LIFE INSURANCE COMPANY, INC. 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 S.USA LIFE INSURANCE COMPANY, INC. 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 S.USA LIFE INSURANCE COMPANY, INC. in writing at their Medicare Supplement Administrative Office: P.O. Box 10853, Clearwater, Florida 33757-8853. I understand that such revocation will not have any effect on actions S.USA LIFE INSURANCE COMPANY, INC. 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.

Do you agree? Yes

## SECTION 9: Signature options available in eApp tool

- \***Verbal Authorization**-this is no signature required
- \***Electronic Signature through Email**- Email client for signature
- \***Face to Face Signature(in-person)** -client will be able to sign on tablet or touchscreen computer.

### VERBAL AUTHORIZATION OPTION

- 13 If selected Verbal Authorization- MUST READ ALL DISCLOSURES TO APPLICANT AND ANSWER AUTHORIZATIONS

**PROSPERITY** Sales Tools

As a convenience to me, I hereby authorize the Company to make withdrawals from my account with the Financial Institution identified in this application for the purpose of paying insurance premium on the above-listed policy. I agree that the withdrawals made on such Financial Institution shall constitute due notice of premiums being due upon the policy. The withdrawals reflected on my bank statement will constitute a receipt. I understand that written notification to discontinue OR to make a change to an EFT withdrawal must be received in our Administrative Office five (5) days prior to the next withdrawal date. I understand that if any account withdrawal is not paid upon presentation and any premiums due on the policy are not paid within the time stipulated in the policy, insurance coverage may lapse or may be terminated by the Company. I understand that this authorization is revocable only upon receipt by the Company of a written notice of revocation.

Yes

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."

**OTHER AUTHORIZATIONS AND DISCLOSURES** 14

Please enter the applicant's mother's maiden name for verification and security.

kutz Yes

\*\*\*\*\*IMPORTANT\*\*\*\*\*

If your policy is issued during your Open Enrollment period, it will contain up to a six (6) month waiting period on pre-existing conditions unless you provide proof you are replacing Creditable Coverage. If you qualify as an eligible person, any waiting period will be waived for the period of time Creditable Coverage was provided.

**Agent's Certification** 15

Writing Number: B02010508 (Level) Yes

Mail Policy to: Agent Yes

I certify that during an interview with the proposed applicant, I have truly and accurately recorded in the application the information supplied by the applicant. Yes

**Completion and Signature** 16

I certify that I have provided the following documents:

- Application Packet (phone sales only)
- A Guide to Health Insurance for People with Medicare
- Outline of Medicare Supplement Coverage
- MIB Notice

By Mail Yes

Provided On Date: 06/28/2017

*Agent* 17

- 14 Enter applicant's mother's maiden name. This will be verified during the phone verification interview conducted at a later time.

- 15 Agent information- verify agent writing number. Select where you wish to have the policy sent- to agent or to client.

- 16 Send all required forms using the method of choice application pdf, OOC, HIPAA and state specific forms

- 17 Agent Signature- will be automatically populated

**Application: Jane Doe** Exit Without Saving

Preview

**S.USA LIFE INSURANCE COMPANY, INC.  
SBLI USA LIFE INSURANCE COMPANY, INC.**

**Fax Application Transmittal Cover Sheet**

**Important:**

- Use this form for **NEW** application submissions.
- Only applications paying the initial premium by bank draft should be faxed.
- **DO NOT** collect premium with an application that is being faxed.
- All applications submitted with this form must be written by the same agent.
- Please use one transmittal per application.
- Do not mail in applications/forms once you have faxed them, original copies should be maintained in case of fax transmission problems.
- Complete all Agent information in the box below.
- **DO NOT** fax documents or corrections requested by Underwriting to the number below (2<sup>nd</sup> applications, replacement forms or other additional documents).

Fax **New applications** and corresponding documents **ONLY** to: 1-855-227-7849

Download/Print Application - Submit to the Carrier **18**

- 18** Review application and download for your records (Optional).  
Once you are ready “Submit to carrier” and your done!

**DO NOT PRINT APPS AND FAX TO CARRIER ONCE APPLICATION HAS BEEN “SUBMITTED TO CARRIER”**

**Application: Jane Doe** Exit Without Saving

**SECTION 9: AUTHORIZATION – PLEASE READ AND SIGN BELOW** **19**

How would you like this application to be signed?  
Email for a Signature ✓

Enter the email to send the signature link  
janedoe@gmail.com ✓

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, 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 provide to S.USA LIFE INSURANCE COMPANY, INC., or its reinsurers, any such information. I understand that I am authorizing S.USA LIFE INSURANCE COMPANY, INC. to receive my health information and prescription drug usage history. The released information received by S.USA LIFE INSURANCE COMPANY, INC. 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.

The signature link has been sent to the applicant. You will be notified once they sign. x

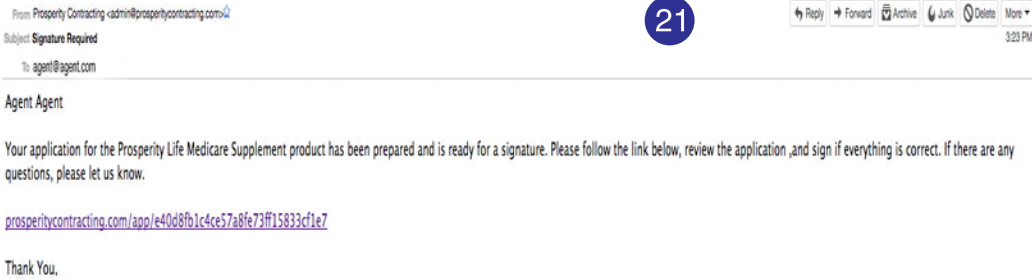
**Application: Jane Doe** Exit Without Saving

Preview

## 2nd OPTIONAL Submission Electronic Signature through Email

- 19** Select Email for a signature option  
Enter applicant’s email address
- 20** Once applicant receives the application- they will be prompted to open and

## Example Email applicant email



21 Applicant will click on link in email.

22

Authenticate

**PROSPERITY**<sup>SM</sup>  
LIFE INSURANCE GROUP  
SBLI USA Life Insurance Company, Inc.  
S.USA Life Insurance Company, Inc.

To access your application, you need to verify your identity.  
Please enter the last 4 digits of your social security number.

Last 4 of your SSN

Go

BENCHMARK  
ADMINISTRATION

22 Applicant will enter the last 4 of SSN  
Applicant will review application and submit to carrier. You are done!

If you have any questions or need assistance  
Please contact us : Call: 1-855-321-2755