PAN AMERICAN LIFE INSURANCE COMPANY

A member of the Pan-American Life Insurance Group

Medicare Supplement

UNDERWRITING GUIDE

PAN-AMERICAN LIFE INSURANCE COMPANY
ADMINISTRATIVE OFFICE
PO BOX 27248, SALT LAKE CITY, UT 84127-0248
STATE OF DOMICILE: LOUISIANA

PANMED-UWG-121719

CONTACT INFORMATION

Addresses for Mailing New Business and Delivery Receipts
When mailing your new business applications and delivery receipts please use the information below:

Mailing Address

Pan-American Life Insurance Company
Administrative Office
PO BOX 27248
Salt Lake City, UT 84127-0248

Overnight/Express Address

Pan-American Life Insurance Company
Administrative Office
1405 West 2200 South
Salt Lake City, UT 84119

Phone, Fax & E-mail

Toll Free: 855-777-0400
New Business Fax: 888-433-4795

INTRODUCTION

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare Supplement insurance. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. To ensure we accomplish this goal, the producer or applicant will be contacted directly by New Business if there are any problems with an application.

POLICY ISSUE GUIDELINES

All applicants must be covered under Medicare Part A and B on the effective date of the policy. 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 your introductory materials for required forms specific to your state.

Open Enrollment

To be eligible for Open Enrollment, an applicant must be at least 64 ½ 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 beginning the first of the month in which the applicant turns age 65.

Additional Open Enrollment Periods

Missouri: Applicants that terminate a Medicare supplement policy within 30 days of the annual policy anniversary date may obtain the same plan on a guaranteed issue basis for a period of 63 days after the termination of their existing policy from an insurer that offers that plan. Include documentation to verify the plan information, paid-to-date and the policy anniversary of the current coverage. For policies with an effective date of 6/1/2010 or later, applicants with existing plans E, H, I or J can convert to one of the following plans: A, B, C, F, or G. Plan F is only available for Medicare prior to January, 2020. Plan G is only available to clients eligible for Medicare 1/1/2020 or later.

States currently with Under Age 65 Requirements:
The following states require that Pan-American Life Insurance Company offer coverage to applicants under age 65. In all other states, applicants under age 65 are not eligible for coverage.

Colorado	All plans available. Open Enrollment if applied for within six months of Part B enrollment.
Florida	All plans available. Open Enrollment if applied for within six months of Part B enrollment.
Georgia	All plans available. Open Enrollment if applied for within six months of Part B enrollment.
Illinois	All plans available. Open Enrollment if applied for within six months of Part B enrollment.
Kansas	All plans available. Open Enrollment if applied for within six months of Part B enrollment.
Kentucky	All plans available. No Open Enrollment. Guaranteed Issue available (not all plans) only if a client has an employer sponsored group plan or Medicare Advantage plan that has been terminated or no longer available.
Louisiana	All plans available. Open Enrollment if applied for within six months of Part B enrollment.
Maryland	Plan A only. Open Enrollment if applied for within six months of Part B enrollment.
Mississippi	All plans and available. Open Enrollment if applied for within six months of Part B enrollment.
Missouri	All plans and available. Open Enrollment if applied for within six months of Part B enrollment.

Montana Plans A, F or G. (plan F is only available to those eligible for Medicare prior to 1/1/2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later)
Open enrollment if applied for within six months of Part B enrollment.

New Jersey Plans C available to clients age 50-64
Open enrollment if applied for within six months of Part B enrollment.

North Carolina Plan A or F only (Plan F is only available to those eligible for Medicare prior to 1/1/2020)
Open enrollment if applied for within six months of Part B enrollment.

Oklahoma Plan A only.
Open Enrollment if applied for within six months of Part B enrollment.

Pennsylvania All plans available.
Open Enrollment if applied for within six months of Part B enrollment.

Texas Plan A only.
Open Enrollment if applied for within six months of Part B enrollment.

Tennessee All plans available. (plan F is only available to those eligible for Medicare prior to 1/1/2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later).
Open Enrollment if applied for within six months of Part B enrollment for persons who do not have access to alternative forms of health insurance coverage because of termination or an action unrelated to the client's status, conduct or failure to pay premium, or persons who are involuntarily disenrolled from Title XIX (Medicaid) or Title XXI (State Children's Health Insurance Program) of the Social Security Act.
Alternate forms of health insurance include accident and sickness policies, employer sponsored group health coverage or Medicare Advantage plans.

Wisconsin Base plan and riders available. The Part B deductible rider is not available for clients Medicare eligible 1/1/2020 or later.

Selective Issue

Applicants over the age of 65, or under age 65 in the states listed above, and at least six months beyond enrollment in Medicare Part B and not applying during a qualified Guaranteed Issue period will be selectively underwritten. 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. Coverage will be declined for those applicants who are outside the established height and weight guidelines.

Applications signed by a Power of Attorney will not be accepted for Selective Issue.

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** – 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:

1. Between age 64 ½ and 65 – The first of the month the individual turns age 65.
2. All Others – Application date or date of termination of other coverage, whichever is later.
3. Effective date cannot be the 29th, 30th, or 31st of the month.

Replacements

A "replacement" takes place when an applicant wishes to exchange an existing Medicare Supplement policy/certificate from Pan-American Life Insurance Company (internal), or any other company (external), for a newer or different Medicare Supplement policy. Internal replacements (in most instances known as a Plan Change) are processed the same as external replacements, requiring a fully completed application.

If an applicant has had a Medicare Supplement policy issued by Pan-American Life Insurance Company within the last 60 days, any new applications will be considered to be replacement applications. If more than 60 days has elapsed since prior coverage was inforce, then applications will follow normal underwriting rules.

A policy owner wanting to apply for a non-tobacco plan must complete a new application and qualify for coverage.

The policy/certificate to be replaced must be inforce on the date of replacement. 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 should accompany the application. The replacement cannot be applied for on the exact same coverage with Pan-American Life Insurance Company.

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

Reinstatements

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. Renewal commission rates will continue based on the policy's duration.

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.

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.

Pharmaceutical Information

Pan-American has implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. In order to obtain the pharmaceutical information as requested, please be sure to include a completed "Authorization to Release Confidential Medical Information (HIPAA)" form with all underwritten applications. This form can be found in the Application Packet. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This additional information will not be solely used to decline coverage.

Policy Delivery Receipt

Delivery receipts are required on all policies issued in Louisiana and Nebraska. Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the client. The second copy must be returned to Pan-American's Administrative Office by mail, email or fax. Please reference page two for contact information.

In Kentucky and Nebraksa the policy is allowed to be mailed directly to the insured. If this option is elected, the delivery receipt does not need to be included in the policy package. If the policy is not mailed directly to the insured a delivery receipt will be included in the policy package.

Guaranteed Issue Rights

If the applicant(s) fall under one of the Guaranteed Issue situations listed below, proof of eligibility must be submitted with the application. In addition to the documents identified, proper proof may include a letter of creditable coverage from the previous carrier or a letter from the applicant's employer.

The situations listed below can also be found in the *Guide to Health Insurance*.

Note: All plans we offer are not available Guaranteed Issue. In Wisconsin, all plans available for all guaranteed issue situations but the Part B deductible rider is only available to those eligible for Medicare prior to 1/1/2020

Guaranteed Issue Situation	Client has the right to buy. . .
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: In this situation, state laws may vary.	Medigap Plan A, B, C, F, or G, K or L that is sold in client's state by any insurance company. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later. If client has COBRA coverage, client can either buy a Medigap policy/certificate right away or wait until the COBRA coverage ends.
Client is in the original Medicare Plan and has a Medicare SELECT policy/certificate. Client moves out of the Medicare SELECT plan's service area. Client can keep the Medigap policy/certificate or he/she may want to switch to another Medigap policy/certificate.	Medigap Plan A, B, C, F or G, K or L that is sold by any insurance company in client's state or the state he/she is moving to. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy/certificate coverage otherwise ends through no fault of client.	Medigap Plan A, B, C, For G, K or L that is sold in client's state by any insurance company. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.

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 documentation 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

Guaranteed Issue Rights for Voluntary Termination of Group Health Plan

Note: All plans we offer are not available Guaranteed Issue.

State	Qualifies for Guaranteed Issue...
CO, IL, MT, PA, TX, OH, LA, IN, WI, NJ	If the employer sponsored plan is primary to Medicare.
IA	If the employer sponsored plan's benefits are reduced, but does not include a defined threshold.
OK, VA	If the employer sponsored plan's benefits are reduced substantially.
FL, KS , MO	No conditions; always qualifies.

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. This definition will be used to satisfy IA, VA and OK requirements. Proof of coverage termination is required.

Proof of Voluntary Termination: Under the state specific Voluntary Termination 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, OK and VA provide proof of change in benefits from employer or group carrier

Guaranteed Issue Rights for Loss of Medicaid Qualification

Note: All plans we offer are not available Guaranteed Issue.

State	Open Enrollment	Client has the right to buy. . .
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, F or G (including F with a high deductible), 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. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
UT	Client is enrolled in Medicaid and is involuntarily terminated. Guaranteed Issue beginning with notice of termination and ending 63 days after the termination date.	Medigap Plan A, B, C, F or G (including F with a high deductible), K or L offered by any Issuer. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
KS	Client loses eligibility for health benefits under Medicaid. Guarantee Issue beginning with notice of termination and ending 63 days after termination date.	Any Medigap plan offered by an issuer. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
MT	Client is enrolled in Medicaid and is involuntarily terminated. Guaratneed issue beginning with notice of termination and ending 63 days after the termination date.	Any Medigap plan offered by an issuer. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
WI	Client is eligilble for benefits under Medicare and is covered under Medicaid, and subsequently loses eligibility for Medicaid. Guarantee issue is available beginning with the date on the notice of termination and ending 63 days after the termination date.	All plans and riders are available. The Part B deductible rider is not available to clients eligible for Medicare1/1/2020 or later.
TN	Client is age 65 or older and covered under Medicare Part B, and is also enrolled in Medicaid (TennCare) and the enrollment involuntarily ceases. The client has a Guaranteed Issue period beginning with notice of termination and ending 63 days after the termination date. Client, under age 65, loses Medicaid (TennCare) coverage. The client has a six month Open Enrollment period beginning on the date of involuntary loss of coverage.	Medigap Plans A, B, C, F or G (including F with a high deductible), K or L offered by an issuer. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later. Any Medigap plan offered by an issuer. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.

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 – Feb. 14th of every year	MA enrollees to disenroll from any MA plan and return to Original Medicare The MADP does not provide an opportunity to: Switch from original Medicare to a Medicare Advantage Plan Switch from one Medicare Advantage Plan to another 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

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

Disenroll during AEP and MADP

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. A copy of the letter the applicant sent to his/her MA plan requesting disenrollment. Letter must be addressed to the current carrier with the address block or fax number

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.

Guaranteed Issue Rights

The situations listed below can also be found in the *Guide to Health Insurance*.

Note: All plans we offer are not available Guaranteed Issue.

Guaranteed Issue Situation	Client has the right to…
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, F or G, K or L that is sold in the client's state by any insurance carrier. Client must switch to original Medicare Plan. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
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. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
Client dropped his/her Medigap policy/certificate to join an MA Plan for the first time, have been in the plan less than a year and want to switch back.	Obtain client's Medigap policy/certificate back if that carrier still sells it. If his/her former Medigap policy/certificate is not available, the client can buy a Medigap Plan A, B, C, F or G, K or L that is sold in his/her state by any insurance company. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
Client leaves an MA plan because their insurance company has not followed the rules or has misled the client.	Buy Medigap plan A, B, C, F or G, K or L that is sold in the client's state by any insurance company. Plan F is only available to those eligible for Medicare prior to January 1, 2020. Plan G is only available to those eligible for Medicare 1/1/2020 or later.
For Wisconsin only - Clients group health plan ended and the client joined a MA plan for the first time. MA plan has been in effect for less than one year and the client wants to switch back to original Medicare	Buy any Medigap plan and riders, but the Part B deductible rider is only available to those eligible for Medicare prior to 1/1/2020.

If you believe another situation exists, please contact the client's local SHIP office.

PREMIUM

Calculating Premium

Utilize Outline of Coverage

- Determine the ZIP code where the client resides and find the correct rate page for that ZIP code.
- Determine the appropriate Plan.
- Determine whether non-tobacco or tobacco.
- Find the applicant's 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:

Colorado, Iowa, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersery, North Carolina, Ohio, Pennsylvania, Tennessee, Utah, Virginia and Wisconsin

Utilizing the Calculate Your Premium Form

- Enter the **base** premium on the first line and proceed with the instructions on the form.

Types of Medicare Policy Ratings

- **Community Rated** - The same monthly premium is charged to everyone who has the Medicare policy, 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 policy is purchased. 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.

Rate Type Available by State

State	Tobacco / Non-Tobacco Rates	Gender Rates	Attained, Issue, or Community Rated	Tobacco Rates During Open Enrollment or G/I
AL	Y	Y	A	Y
AZ	Y	Y	I	Y
CO	Y	Y	A	N
FL	Y	Y	I	Y
GA	Y	Y	I	Y
IA	Y	Y	A	N
IL	Y	Y	A	N
IN	Y	Y	A	Y
KS	Y	Y	A	Y
KY	Y	Y	A	N
LA	Y	Y	A	N
MD	Y	N	A	N
MI	Y	Y	A	N
MO	Y	Y	I	N
MS	Y	Y	A	Y
MT	Y	N	A	Y
NC	Y	Y	A	N
NE	Y	Y	A	Y
NJ	Y	Y	A	N
OH	Y	Y	A	N
OK	Y	Y	A	Y
PA	Y	Y	A	N
SC	Y	Y	A	Y
TN	Y	Y	A	N
TX	Y	Y	A	Y
UT	Y	Y	A	N
VA	Y	Y	A	N
WI	Y	Y	A	N

Height and Weight Chart

Eligibility

To determine whether the client may purchase coverage, locate their height then weight in the chart below. If their weight is in the Decline column the client is not eligible for coverage at this time. If the client's weight is located in the Standard column, you may continue with the application.

	Decline	**Standard**	**Decline**
Height	Weight	Weight	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 +
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/Policy Fee

There will be a one-time enrollment/policy fee of $25.00 ($6.00 in Mississippi) that must be collected with each applicant's initial Medicare Supplement premium payment. This will not affect the renewal premiums.

Completing the Premium on the Application

Effective Date

- The effective, or draft date cannot be on the 29th, 30th or 31st of the month.

Premium Collected

- Indicate the amount of premium collected with the application on the Premium Collected box located on the application.

Renewal Premium

- Determine how the client wants to be billed going forward (**renewa**l) and select the appropriate mode on the Renewal Mode section on the application.
- Indicate, based on the mode selected, the renewal premium. **Monthly direct billing is not allowed.**

NOTE: If utilizing Electronic Funds Transfer (ACH) as a method of payment, please complete Section 5, Billing Information, of the application. If paying the initial premium by ACH, this section must be completed and submitted with the application. The policy will NOT be issued until the billing information is received. At this time, Pan-American's Administrative Office does not accept payments by credit/debit cards.

Collection of Premium

At least one month's premium and enrollment/policy fee must be submitted with the application.

- If a mode other than monthly is selected, then the full modal premium including any enrollment/policy fee must be submitted by live check; or
- If the applicant chooses to pay the first month's premium and enrollment/policy fee with a live check and draft the remaining monthly premiums via ACH, then the applicant can choose monthly ACH only. The completed authorization form needs to be dated, signed and submitted with the application; the live check will cover the first month's premium and enrollment/policy fee, and all subsequent monthly premium will draft via ACH; or
- If the applicant chooses to pay the monthly premium and enrollment/policy fee through ACH, the completed authorization form needs to be dated, signed and submitted with the application. The first month's premium and enrollment/policy fee will be drafted immediately upon policy issuance. All subsequent monthly premium will draft via ACH.

NOTE: Pan-American's Administrative Office **does not** accept post-dated checks, Money Orders, Cashier Checks, or payments from Third Parties; including any Foundations, as premium for Medicare Supplement policies. Immediate family and domestic partners are acceptable payors.

Business Checks

If premium is paid by a business account, complete the information located in the Billing Information section (Section 5) of the application.
Business checks will only be accepted if the applicant is the owner of the business or a spouse of the owner.

Premium Billing

- The first premium is billed when the policy is issued, unless otherwise requested. Premium can be drafted after the policy is issued, but no later than the policy effective date. **If the client wishes to have the initial premium drafted on a certain date, please indicate this in the Billing Information section of the application**.
- Billing is completed in advance unless the bank draft day is within 14 days of the premium due date. **If the bank draft day is not within 14 days of the premium due date, the policy will bill in advance.**

Example 1

Client chooses an effective date of 3/1 and wants premiums drafted on the 5th. The premium will draft on the 5th of each month, and pay the policy current to the next month. In this example, the initial premium pays the policy from 3/1 - 4/1. The next premium billing date will be 4/5 which will pay the premium to 5/1.

Example 2

Client chooses an effective date of 3/1 and wants premiums drafted on the 15th. In this example, because the bank draft day is more than 14 days from the effective date, the premium will bill in advance. In this example, the initial premium will pay the policy from 3/1 - 4/1. On 3/15, the premium will be drafted to pay the policy from 4/1 - 5/1.

Initial Premium Receipt

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

NOTE: Do **not** mail a copy of the receipt with the application.

Shortages

Pan-American will reduce the agent's commissions by the amount of any premium shortage, due to an error in calculation, equal to or less than $5. However, if the enrollment/policy fee **is not** included with the initial premium Pan-American will reduce the agent's commissions by an amount not to exceed $25 per application. Pan-American's Administrative Office will communicate with the producer by telephone, e-mail or FAX in the event of a premium shortage greater than the $5/$25 thresholds. The application will be held in pending until the balance of the premium is received. Producers may communicate with us by calling 855-777-0400 or by FAX 888-433-4795.

Refunds

Pan-American will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

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.

APPLICATION

Properly completed applications should be finalized within approximately 5-7 days of receipt at Pan-American's Administrative Office. The ideal turnaround time provided to the producer is approximately 11-14 days, including mail time.

Application Sections

Please review all sections of the application before submitting.

Section 1 - Plan Information

- The entire section must be completed.
- This section should indicate the plan or policy form selected and where the policy should be mailed to.
- This section allows producers to indicate where they wish a policy to be delivered for each applicant. The policy can be sent to either the producer or the applicant. However, the policy will always be sent to the producer if:
  - There is a premium shortage or other outstanding application requirement.
  - The applicant(s) lives in a state that requires a delivery receipt (Louisiana or Nebraska).
  - No preference is selected.

Section 2 - Applicant Information

- Please complete the client's residence address in full. If the applicant has a mailing address other than residence address, please complete the mailing address in full.
- Age and Date of Birth are the **exact age** as of the **application date.**
- The Medicare Card number, also referred to as the Health Insurance Claim (HIC) number, is vital for electronic claims payment
- Height/Weight — This is required on underwritten cases
- Tobacco use - Answer this question for all underwritten applications. Do not answer this question when applying for Open Enrollment or Guarantee Issue if applying in Colorado, Iowa, Illinois, Kentucky, Louisiana, Maryland, Michigan, Missouri, New Jersey, North Carolina, Ohio, Pennsylvania, Utah, Virginia and Wisconsin.

- End stage renal disease - Answer for all applications.

Section 3 — Medicare Eligibility

- Verify the applicant answered "Yes" to receiving the *Guide to Health Insurance* and Outline of Coverage, it is a requirement that these two documents be left with the client at the time the application is completed.
- Please indicate the applicant's effective/eligibility dates of Medicare Part A and B.

Section 4 — Insurance Policies/Certificates

- If the applicant is applying during a Guaranteed Issue period, be sure to include proof of eligibility.
- If the applicant is replacing another Medicare Supplement policy/certificate, complete question #2 and include the replacement notice.
- If the applicant is leaving a Medicare Advantage plan, complete question #3 and include the replacement notice.
- If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union, employer plan, or other non-Medicare Supplement coverage, complete question #4 and include proof of termination.
- 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 policy, then the applicant is not eligible for coverage.

Section 5 — Billing Information

- Include the enrollment/policy fee with the initial premium when applying for Medicare Supplement. If the fee is not shown in the amount collected, the enrollment/policy fee will be charged to the agent's commission account.
- If the applicant would like to have his/her payment deducted from their checking or savings account, complete the banking section and have the applicant or account holder, if different, sign.
  NOTE: The requested draft day cannot be the 29th, 30th or 31st of the month. If a monthly billing mode is chosen, the applicant must complete this section.

Section 6 — Household Discount

- To qualify for a Household Discount, the entire section of the application must be completed. Refer to the chart on page 18 for state specific discount eligibility criteria.

Section 7 — Health Questions

- If the applicant is applying during an Open Enrollment or a Guaranteed Issue period, do not answer the health questions or prescription information.
- If the applicant is not considered to be in an Open Enrollment or a Guaranteed Issue situation, all health questions must be answered, including the question regarding prescription medications.
  NOTE: In order 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.

Section 8 — Signatures

- Signatures and dates - Required by both the applicant(s) and producer. The producer must be appointed in the state where the application is signed. If an application is taken on a Kansas resident, the producer must be appointed in Kansas and in the state where the application is signed.
  NOTE: The 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.*
- 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 legal representative should sign their own name as themselves, not as the applicant.
  NOTE: Power of Attorney signatures are not accepted for applicants outside of Open Enrollment or a Guarantee Issue period. Power of Attorney signatures will only be accepted on Open Enrollment or Guarantee Issue applications. A copy of the Power of Attorney documents are required prior to issue.

HOUSEHOLD DISCOUNT STATE SPECIFIC CRITERIA

State	Criteria	Percent
AZ, CO, GA, IA,KY, LA, MD, MI, MO,MS, SC, TN,UT, WI	At least one, no more than 3, household residents age 50 or older: • Continuously resided with for past 12 months, or married or in a civil union partnership OR • Is applying for or has existing policy with Pan-American	12%
FL	At least one, no more than 3, household residents age 50 or older: • Married or in a civil union partnership OR • is applying for or has existing policy with Pan-American NOTE: Both policies must be issued to qualify for the discount	7%
IN	Continuously resided for the past 12 months with your spouse or household resident who has an existing Medicare Supplement or is applying for and issued a Medicare Supplement policy with Pan-American Life Insurance Company. **NOTE: Both policies must be issued to qualify for the discount**	12%
NE	At least one, no more than 3, household residents age 50 or older: • Continuously resided with for the past 12 months, or married or in a civil union partnership OR • Is applying for or has existing policy with Pan-American	12%
NJ	At least one, no more than 3, household residents age 50 or older: who has an existing Medicare Supplement policy with Pan-American or is applying for such a policy. NOTE: Both policies must be issued to qualify for the discount.	7%
OH	Resided with at least one, but no more than three other Pan-American Medicare Supplment policyholders. **NOTE: Both policies must be issued to qualify for the discount**	7%
OK	Resided with at least one, but no more than three other Pan-American Medicare Supplment policyholders. **NOTE: Both policies must be issued to qualify for the discount**	12%
PA	At least one, no more than 3, household residents: • Married or in a civil union partnership OR • Is applying for or has existing policy with Pan-American	12%
TX, VA	At least one, no more than 3, household residents: • Continuously resided with for the past 12 months, or married OR • Is applying for or has existing policy with Pan-American	12%

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 two sections in this guide.

There may, however, be 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 health questions 6, 7 and 8.

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 with "Yes" and attach an explanation stating how long the condition has existed and how it has been controlled. Be sure to include the name, dosages, duration and conditions treated for all prescription medications.

People with diabetes mellitus that require, or have ever required, more than 50 units of insulin daily, or people with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complicating conditions listed in question #15 on the application, 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 less than 50 units of insulin daily or no more than two oral medications for diabetes, and no more than two medications for hypertension. A combination of less than 50 units of insulin a day 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 for at least 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.

Health Question 6 On The Application
Malignant Melanoma is considered an internal cancer. Applicants with this type of cancer are not eligible for coverage. Other types of skin cancer, such as basal cell, are not considered internal.

Uninsurable Health Conditions

Applications should not be submitted if the applicant has ***any history*** of the following conditions:

AIDS	Hypertensive Chronic Renal Disease
Alzheimer's Disease	Nephrotic Syndrome
ARC	Cognitive Disorders
Any cardio-pulmonary disorder requiring oxygen	Cerebrovascular disease with cognitive deficits
Cirrhosis	Dissociative amnesia
Chronic Hepatitis:	Huntington's chorea (Huntington's disease)
Chronic Hepatitis B	Post concussion syndrome with residual deficit
Chronic Hepatitis C	
Chronic Hepatitis D	Diabetes - Insulin > 50 units / day
Autoimmune Hepatitis	Diabetes with history of high blood pressure, taking more than 2 diabetes medications and or more than 2 high blood pressure medications.
Chronic Active Hepatitis	Diabetes with complications such as neuropathy or retinopathy or kidney disease, heart or vascular disease, TIA or stroke.
Chronic Steatohepatitis	
Chronic Obstructive Pulmonary Disease (COPD)	Dementia, including delirium, organic brain disorder or other cognitive impairment.
Other chronic pulmonary disorders to include:	
Asbestosis	Emphysema
Bronchiectasis	HIV
Chronic bronchitis	Kidney Disease requiring dialysis
Chronic Cardiopulmonary Disease	Kidney Failure/End Stage Renal Disease (ESRD) or any kidney disorder that the applicant is being evaluated for or if the applicant is currently on dialysis.
Chronic Obstructive Lung Disease (COLD)	Lateral Sclerosis (ALS)
Chronic asthma*	Lupus - Systemic
Chronic interstitial lung disease	Multiple Sclerosis
Chronic pulmonary fibrosis	Myasthenia Gravis
Cystic Fibrosis	Organ transplant
Pulmonary hypertension	Osteoporosis with related fracture
Chronic Kidney/Renal Disease:	Parkinson's Disease
Chronic Nephritis	Pulmonary Hypertension
Chronic Glomerulonephritis	Rheumatoid Arthritis treated with injectable medications or Methotrexate and Prednisone or more than 25 mg Methotrexate per week
Chronic protein loss in the urine (proteinuria) requiring 4 or more MD office visits per year in the follow-up of renal disease.	Sarcoidosis
Chronic Renal Insufficiency	Scleroderma

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 medication's, including inhalers.
- Taking any medication that must be administered in a physician's office.
- Advised to have surgery, medical tests, treatment or therapy.
- If the applicant's height/weight is in the decline column on the chart.

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 (brand or generic):

3TC	AIDS	**Exelon**	Dementia
Accuneb	COPD	**Extavia**	Multiple Sclerosisi
Acetate	Prostate Cancer	**Fuzeon**	HIV
Alkeran	Cancer	**Galatamine**	Dementia
Amantadine	Parkinson's Disease	**Gilenya**	Multiple Sclerosis
Anoro Ellipta	COPD	**Glatopa**	Multiple Sclerosis
Apokyn	Parkinson's Disease	**Gold**	Rheumatoid Arthritis
Aptivus	HIV	**Haldol**	Psychosis
Aricept	Dementia	**Herceptin**	Cancer
Artane	Parkinson's Disease	**Hydergine**	Dementia
Atripla	HIV	**Hydrea**	Cancer
Aubagio	Multiple Sclerosis	**Hydroxyurea**	Melanoma, Leukemia, Cancer
Avonex	Multiple Sclerosis	**Imuran (Azothioprine)**	Immunosuppression, Severe Arthritis
Azilect	Parkinson's Disease	**Incruse Ellipta**	COPD
AZT	AIDS	***Insulin (>50 units/day)**	Diabetes
Baclofen	Multiple Sclerosis	**Interferon**	AIDS, Cancer, Hepatitis
BCG	Bladder Cancer	**Indinavir**	AIDS
Betaseron	Multiple Sclerosis	**Invega**	Schizophrenia
Bicalutamide	Prostate Cancer	**Invirase**	AIDS
Breo	COPD	**Kaletra**	HIV
Brovana	COPD	**Kemadrin**	Parkinson's Disease
Carbidopa	Parkinson's Disease	**Lasix/Furosemide**	Heart Disease
Casodex	Prostate Cancer	**(>60mg/day)**	
Cerefolin	Dementia	**L-Dopa**	Parkinson's Disease
Cogentin	Parkinson's Disease	**Lemtrada**	Multiple Sclerosis
Cognex	Dementia	**Lenalidomide/Revlimd**	Multiple Myeloma
Combivir	HIV	**Letairis**	Pulmonary Hypertension
Comtan	Parkinson's Disease	**Leukeran**	Cancer, Immunosuppression, Severe Arthritis
Copaxone	Multiple Sclerosis	**Leuprolide**	Prostate Cancer
Crixivan	HIV	**Levodopa**	Parkinson's Disease
Cytoxan	Cancer, Severe Arthritis, Immunosuppression	**Lexiva**	HIV
D4T	AIDS	**Lioresal**	Multiple Sclerosis
DDC	AIDS	**Lomustine**	Cancer
DDI	AIDS	**Lupron**	Cancer
DES	Cancer	**Megace**	Cancer
Daliresp	COPD	**Megestrol**	Cancer
Donepezil	Alzheimer's Disease	**Mellaril**	Psychosis
DuoNeb	COPD	**Melphalan**	Cancer
Ebixa	Alzheimer's Disease	**Memantine**	Alzheimer's Disease
Eldepryl	Parkinson's Disease	**Methotrexate (>25mg/wk)**	Rheumatoid Arthritis
Eligard	Prostate Cancer	**Metrifonate**	Dementia
Embrel	Rheumatoid Arthritis	**Mirapex**	Parkinson's Disease
Emtriva	HIV	**Myleran**	Cancer
Epivir	HIV	**Namenda**	Alzheimer's
Epogen	Kidney Failure, AIDS	**Natrecor**	CHF
Ergoloid	Dementia	**Navane**	Psychosis
Esbriet	Chronic Pulmonary Disorder	**Nelfinavir**	AIDS

Partial List of Medications Associated with Uninsurable Health Conditions (continued).

Medication	Condition	Medication	Condition
Neoral	Immunosuppression, Severe Arthritis	**Trelegy Ellipta**	COPD
Neupro	Parkinson's Disease	**Treslar-LA**	Prostate Cancer
Norvir	HIV	**Triptorelin**	Prostate Cancer
Novatrone	Multiple Sclerosis	**Trizivir**	HIV
Nucala	Chronic Pulmonary Disorder	**Truvada**	HIV
OFEV	Chronic Pulmonary Disorder	**Tudorza**	COPD
Paraplatin	Cancer	**Tysabri**	Multiple Sclerosis
Parlodel	Parkinson's Disease	**Valycte**	CMV HIV
Permax	Parkinson's Disease	**VePesid**	Cancer
Plegridy	Multiple Sclerosis	**Viadur**	Prostate Cancer
Prednisone (>10mg/day)	Rheumatoid Arthritis,COPD	**Videx**	HIV
Prezista	HIV	**Vincristine**	Cancer
Procrit	Kidney Failure, AIDS	**Viracept**	HIV
Prolixin	Psychosis	**Viramune**	AIDS
Provenge	Prostate Cancer	**Viread**	HIV
Razadyne	Dementia	**Zanosar**	Caner
Rebif	Multiple Sclerosis	**Zelapar**	Parkinson's Disease
Remicade	Rheumatoid Arthritis	**Zerit**	HIV
Reminyl	Dementia	**Ziagen**	HIV
Remodulin	Pulmonary Hypertension	**Zinbryta**	Multiple Sclerosis
Requip	Parkinson's Disease	**Zoladex**	Cancer
Rescriptor	HIV	**Zometa**	Hypercalcemia in Cancer
Retrovir	AIDS		
Reyataz	HIV		
Rilutek	Amyotrophic Lateral Sclerosis		
Riluzole	ALS		
Ritonavir	AIDS		
Rivastigmine	Dementia		
Ruxolitinib/Jakafi	myelofibrosis, Polycythemia		
Sandimmune	Immunosuppression, 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		
Thiotepa	Canc		
Thorazine	Psychosis		

MAILING APPLICATIONS TO PROSPECTS

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

The Facts

When Face-to-face Interviews Aren't Possible

Face-to-face interviews are always preferable; however, there will be times when you cannot meet with prospects in person. When necessary, and with the prospect's consent, you may conduct the interview over the phone and mail the completed application to the prospect.

This option is to be used only with people who have responded to lead-generation material or with whom you have on-going client relationships. It is not appropriate for cold calling, as national and corporate do-not-call rules and other compliance requirements apply.

The Sales Process

The method for selling Medicare Supplements does not change - Call a lead, review coverage, ask for the sale, complete and sign the application, submit the business and deliver the policy. The difference is that parts of the sales process may be conducted via the telephone instead of face-to-face. Consequently, there are a few more steps, outlined on the next two pages, to complete the sale.

Improve Time Service

Submitting complete and accurate information ensures quick time service. Other factors are:

- You must be licensed to sell in the state where the prospect is at the time of solicitation; that is the state where he/she is located when you ask the questions on the application.
- If an application is taken on a Kansas resident, you must be appointed in Kansas and in the state where the application is signed.
- The producer who solicits the business must sign the corresponding application.
- You cannot sign blank applications.
- Incomplete application submissions will be returned to you.
- It is not acceptable to mail blank applications, brochures and Outlines of Coverage as prospecting material.

The Process

Please complete the following steps when you conduct the Medicare Supplement sales interview over the phone and mail the completed application to the prospect:

Step	Action:
1	**Call the prospect who responded to a lead.** When you receive a lead, telephone the person to discuss the benefits, rates, and answer questions. Attempt to schedule a face-to-face appointment to review details, ask for the sale and apply for coverage. If the prospect prefers to continue the sales process on the phone, continue to Step 2. **Note:** You must be licensed to sell in the state where the prospect is located during the time of solicitation; that is the state where he/she is located when asked the questions on the application.
2	**Complete the required forms over the telephone.** Ask the prospect all of the questions on the application, replacement notice and state special forms (if needed) and print the answers. Consider repeating his/her responses for accuracy. **Note**: Privacy requirements prohibit discussing eligibility for other products over the telephone.
3	**Mail forms to the prospect.** Place the following in an envelope and mail to the prospect: • Cover letter (attach your business card): - Indicating which forms to sign and what to return to you. - Asking the prospect to verify all information including his/her Medicare Card Number, to make necessary corrections and initial changes (or include a copy of the applicant's Medicare Card). - Inviting the prospect to contact you with any questions. • Application and forms (replacement notice and state special forms, if needed) with signature areas and premium highlighted. • Outline of Coverage, Guide to Health Insurance. • Postage-paid addressed envelope. **Note**: Plan availability and premium rates are based on when the application is signed. The producer must communicate changes in plan availability or premium to the prospect before submitting the forms to Pan-American's Administrative Office.
4	**Prospect reviews and signs forms.** Once the prospect receives the application and forms, he/she: • Verifies the responses and initials any corrections. • Signs the application and forms as highlighted. • Returns the application and forms to the producer in the provided envelope.
5	**Verify and sign forms.** When you receive the envelope from the prospect, you: • Check that you have the first premium payment and the completed and signed application and forms. • Verify that the prospect initialed any changes. • Sign the required items. • Send the Premium Receipt to the applicant. **Note**: The producer who solicited the business must sign the application.
6	**Submit for processing.** Submit the business (application and forms) in the usual manner.
7	**Deliver the policy according to current policy delivery guidelines**.

Questions?
Call us at 855-777-0400

REQUIRED FORMS

Application

Only current Medicare Supplement applications may be used in applying for coverage. A copy of the completed application will be made by Pan-American's Administrative Office and attached to the policy to make it part of the contract.

The agent is responsible for submitting completed applications to Pan-American's Administrative Office:

Mailing Address	Overnight/Express Address
Pan-American Life Insurance Company ***Administrative Office*** PO BOX 27248 Salt Lake City, UT 84127-0248	***Pan-American Life insurance Company*** Administrative Office 1405 West 2200 South Salt Lake City, UT 84119

Phone and Fax
Toll Free: 855-777-0400
Fax: 888-433-4795

Agent/Producer Certification Form

The Agent Certification form must be completed and signed by both the applicant(s) and agent, and submitted with the application.

Premium Receipt

The receipt must be completed and provided to the applicant as receipt for premium collected.

HIPAA Authorization Form

Required with all underwritten applications.

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, and the second signed replacement notice must be submitted with the application.

STATE SPECIAL FORMS

Forms specifically mandated by states to accompany point of sale material (included in the application pack):

Colorado

Commission Disclosure Form – This form is to be completed by the producer, then signed by the producer and applicant. Leave a copy with the applicant and retain a copy in the applicant's file.

Florida

Important Notice Before You Buy Health Insurance – To be left with the applicant.

Iowa

Important Notice Before You Buy Health Insurance – To be left with the applicant.

Illinois

Medicare Supplement Checklist - Form to be completed, signed, dated and a submitted copy to be left with the applicant.

Kentucky

Comparison Statement - Return to Company

Louisiana

Your Rights Regarding the Release and Use of Genetic Information – To be left with the applicant.

Nebraska

Senior Health Counseling Notice – This form is to be left with the applicant.

Pennsylvania

Guaranteed Issue and Open Enrollment Notice - To be left with the applicant.