Sterling Life Insurance Company
Application for Medicare Supplement Insurance

P.O. Box 5348 ~ Bellingham, WA 98227 ~ 800/688-0010

1. Applicant Information

Insured's Name (as it appears on Medicare Card) ______________________________
LAST FIRST MI

Medicare ID # ____________________ Social Security # ____________________

☐ Yes, I am insured under Medicare Part A and B / Part B Effective Date ______________

Physical Address ________________________________ Phone Number ______________

City ____________________ County ______________ State _____ Zip __________

Mailing Address ____

City ____________________ County ______________ State _____ Zip __________

Age (at Requested Effective Date) ________ Date of Birth ___ / ___ / ___ Gender ☐ M ☐ F

2. Requested Effective Date ___ / ___ / ___

3. Medicare Supplement Coverage Options

Standard: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Innovative Plan F ☐ Plan G ☐ Plan K ☐ Plan N

SELECT: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan F ☐ Innovative Plan F ☐ Plan G ☐ Plan K ☐ Plan N

4. Payment Options

Monthly: ☐ Coupons ☐ Automatic Bank Draft

Statement: ☐ Quarterly ☐ Semi-Annually ☐ Annually

Premium Amount Collected
$__________

5. Power of Attorney/Guardian

Have you authorized any person to legally act on your behalf and take over your personal business transactions (POA, Guardian, etc.)? ☐ Yes ☐ No

If Yes, Name (Please include documentation) ______________________________

Address ____________________ City ______________ State _____ Zip ________

Should all mailings go to POA, Guardian, etc. at this address? ☐ Yes ☐ No

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:

6. (a) Did you turn age 65 in the last 6 months?: ☐ Yes ☐ No
(b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
(c) If yes, what is the effective date of Part B? ____/___/_____

7. 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 this question.

If Yes,
(a) Will Medicaid pay your premium for this Medicare supplement policy? ☐ Yes ☐ No

(b) Do you received any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

8. (a) If 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), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ___/___/___ END___/___/____

(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

(c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

(d) Did you cancel a Medicare supplement policy prior to enrolling in this Medicare plan? ☐ Yes ☐ No

9. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

(b) If so, with what company, and what plan do you have? ____

(c) If so, so you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

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

(a) If so, with what company and what kind of policy? ____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START ___/__/___ END ___/__/_____

I UNDERSTAND IT IS MY OBLIGATION AND RESPONSIBILITY TO DISENROLL MYSELF FROM MY PRESENT MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE PROGRAM. NEITHER THE AGENT NOR THE INSURANCE COMPANY HAS THE AUTHORITY TO DISENROLL ME FROM THE PROGRAM.

Applicant's Signature ____

****If you are applying during an open enrollment or guaranteed issue period, you do not have to answer Health Questions 11 or 12.**

11. If any of the following questions are answered "Yes" the applicant is uninsurable.

A. Within the past two years, have you received any medical advice or treatment by a member of the medical profession, or been hospitalized for any of the following:

1. Stroke, heart attack, coronary artery disease including angina, arteriosclerosis or artherosclerosis or congestive heart failure? ☐ Yes ☐ No
2. Cancer (excluding skin), Leukemia, Hodgkins' Disease or Melanoma? ☐ Yes ☐ No
3. Alzheimer's Disease, Parkinson's Disease, Lou Gehrig's Disease or ALS, Multiple Sclerosis or Muscular Dystrophy? ☐ Yes ☐ No
4. Chronic Obstructive Lung / Pulmonary Disease or Emphysema? ☐ Yes ☐ No
5. Alcoholism, Drug Addiction, Cirrhosis of the Liver or Renal Failure? ☐ Yes ☐ No
6. Insulin Dependent Diabetes or Rheumatoid or Disabling Arthritis? ☐ Yes ☐ No
7. Have you required oxygen therapy, kidney dialysis, a defibrillator, bypass surgery, angioplasty, pacemaker or stent placement? ☐ Yes ☐ No

B. Have you been diagnosed or treated by a member of the medical profession as having AIDS

(Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex) or tested positive for HIV virus? ☐ Yes ☐ No

12. **Within the past two years, have you been confined to or utilized: a hospital, skilled nursing facility, nursing home, ambulatory surgery center or another similar facility?**
If "Yes", please explain below: ☐ Yes ☐ No

Condition	Onset Date	Operation Date	Recovery Date	Days in Hospital	Days in Nursing Facility

A. Please indicate your height and weight: ______ Ft. ______ In. / ______ Lbs.

B. Have you used tobacco products in the last two years? ☐ Yes ☐ No

C. **Agent**: List all policies you have sold to the applicant, including those no longer in force, if sold in the last five years (if none, state "none"):

Policies sold which are still in force: ____________________

Policies sold in the past five years which are no longer in force: ____________________

13. **Acknowledgments**. The Applicant, to the best of his / her knowledge and belief, represents and agrees as follows:

A. 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.

B. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy

C. If, after purchasing this policy, you become eligible for Medicaid, benefits and premiums under the Medicare Supplement policy will be suspended during entitlement to benefits under Medicaid for 24 months, as long as suspension is requested within 90 days of becoming eligible for Medicaid. When 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 reinstated if requested within 90 days of losing Medicaid eligibility.

D. 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 your 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.

E. Counseling services may be available in your state to provide advice concerning the purchase of Medicare Supplement coverage 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).

F. That the statements contained in the application concerning past and present health conditions are complete, true and correct.

G. No agent or other person is authorized to accept risks, pass upon insurability, make or modify contracts or waive any of the Company's rights or requirements.

H. Insurance issued as a result of this application will take effect as specified in the Conditional Receipt.

I. Plan provisions concerning exceptions, exclusions, limitations and renewal which have been applied for have been explained and understood.

J. The Applicant acknowledges receipt of the **Outline of Coverage** and the **Guide to Health Insurance for People with Medicare.**

14. **Representation**. The undersigned applicant and agent acknowledge that the applicant has read or has had read to him / her the completed application and that he / she realizes that any false statements or misrepresentation therein may result in loss of coverage under the policy.

15. **Payment of Premium**. Read the Conditional Receipt before signing this Application. This is to acknowledge that I have read the Receipt and fully understand its conditions and limitations. I understand that no agent can waive or change the conditions and limitations of the Conditional Receipt.

16. **Release**. In connection with an application for insurance currently made to Sterling, I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, or other organization, institution or person, that has any records or knowledge of me or any members of my family named in said application or of my health, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. This authorization shall be valid for a period of two years and six months from the date signed.

17. **Release for claims processing**. I further authorize Sterling, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Centers for Medicare and Medicaid Services (CMS), or its duly appointed Part A intermediaries or Part B carriers to release to Sterling information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include EOMBs, "deduct-not-met" or denial letter, Part B billing forms, and information date of enrollment in Part B of Medicare. I further authorize ongoing release of this information to Sterling for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Sterling in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, that I will need to fill out claims forms and some records could be released before the rescission has time to take effect.

Dated at City ______________________________ State _____________ Zip ______________

Applicant's Signature ____ Date ______________

Agent Witness. I have witnessed the signature of the Applicant. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ is or is likely; ☐ is not or is not likely to replace or change any existing policy (ies) or contract(s).

Signature of Licensed Agent __________________________________ Agent # ______________

Print Name ____ Office ID ______________

NOTICE. It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the appropriate State Agency.

For Administrative Purposes Only: