	YES	NO
7. Do you have another **Medicare Supplement** policy in force?	☐	☐
If yes,		
a. Do you intend to replace your current Medicare Supplement policy with this policy?	☐	☐
If yes, what is your planned date of termination/disenrollment? _____ Month Day Year		
b. With what company and what plan do you have?		
Company _____		
Plan (e.g. Plan F, Plan G) _____		

	YES	NO
8. Have you had coverage under any **other health insurance** within the past 63 days? (For example, an employer, union or individual plan)	☐	☐
a. If so, with what company and what kind of policy?		
Company _____		
☐ Employer Plan ☐ Union Plan ☐ Individual Plan ☐ Other _____		
b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave "END" blank) Start Date _____ Month Day Year End Date _____ Month Day Year		
c. If you are still covered by the policy described above, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐
If yes, what is your planned date of termination/disenrollment? _____ Month Day Year		

Information about your Health

The answers you provide in this section help us determine if you qualify for coverage. If you qualify for Open Enrollment or provide a copy of a notice you received from your prior insurer indicating you are eligible for Guarantee Issue, you do not need to answer questions 9–20.

9. Please provide your height _____(ft./in.) and weight _____(lbs.)

Answer questions 10–13.	YES	NO
10. Within the past 24 months, have you had, been treated for, or been told by a medical professional that you have any of the following:		
• chronic kidney disease (stages 3, 4 or 5); kidney failure or kidney disease requiring dialysis	☐	☐
• internal cancer; cancer in need of surveillance or cancer that has gone into remission within the past two years; blood cancer(s); leukemia; lymphoma; melanoma or a non-routine medical test to rule out or confirm the presence of cancer that has not been completed	☐	☐
• diabetes requiring the use of insulin or any diabetes when in combination with heart disease (excluding high blood pressure)	☐	☐
• arthritis that restricts mobility or daily activities, requires physical therapy, requires major joint (hip, knee, shoulder) injection(s) or you have been advised to have a joint replacement; Rheumatoid Arthritis	☐	☐
• liver disease; cirrhosis; alcoholism or drug abuse	☐	☐
• bipolar disease; schizophrenia or any other psychotic disorders	☐	☐
• drugs administered by intravenous (IV) infusion, other than during an emergency room visit, hospitalization, or surgery	☐	☐
11. Do you use oxygen as treatment for diagnosed medical condition?	☐	☐
12. Have you been admitted to the hospital within the past three months?	☐	☐
13. Has a medical professional advised or discussed as a treatment option that you may need surgery (includes cataract surgery) or drugs administered by intravenous IV infusion?	☐	☐

Note: If you answered "YES" to any item in question 10–13, you will not qualify for coverage.

Answer questions 14–20 only if you will be 69 years of age or older on the effective date of the coverage for which you are applying. Otherwise, skip questions 14–20.

	YES	NO
14. Within the past 24 months, have you had, been treated for, or been told by a medical professional that you have any of the following:		
• coronary artery disease; heart attack; heart surgery (includes angioplasty, heart stent, or bypass)	☐	☐
• congestive heart failure; cardiomyopathy; heart valve disorder; atrial fibrillation or other heart rhythm disorder; implanted cardiac defibrillator; pulmonary hypertension; unoperated aneurysm; peripheral vascular disease	☐	☐
• stroke; transient ischemic attack (TIA); carotid artery disease; cerebrovascular disease	☐	☐
• Osteoporosis with fracture; degenerative bone disease; amputation or fracture caused by disease	☐	☐
• chronic obstructive pulmonary disease (COPD); chronic bronchitis; emphysema or any chronic pulmonary disorder	☐	☐
• Myasthenia Gravis; Grave's Disease; systemic lupus erythematosus (SLE)	☐	☐
• Multiple Sclerosis; Amyotrophic Lateral Sclerosis (ALS); Parkinson's Disease.....	☐	☐
• Alzheimer's Disease; dementia, or any other cognitive disorder	☐	☐
• Acquired Immune Deficiency Syndrome (AIDS), and/or Positive HIV and/or AIDS Related Complex (ARC)	☐	☐
15. Have you been hospitalized or confined to a nursing home or residing in an assisted-living facility within the past 90 days, or have you been hospitalized two or more times in the past 12 months?.....	☐	☐
16. Are you confined to a bed, or do you require the use of a wheelchair or any motorized mobility device?....	☐	☐
17. Have you had or been recommended to have an organ or stem cell transplant (excluding cornea transplants)?	☐	☐
18. Has a medical professional advised or discussed as a treatment option that you may need a non-routine medical procedure within the next 12 months?.....	☐	☐
19. Do you have **both** high blood pressure and diabetes **and** any of the following is true: a) take three or more medications for either condition, b) increased dosage or addition of medication for either condition in the past two years, c) have diabetic complications (peripheral neuropathy; diabetic retinopathy).	☐	☐

Note: If you answered "YES" to any of questions 14-19, you will not qualify for coverage.

20. In the past 12 months, have you taken or been advised to take any prescription medication(s)? If "YES", indicate the specifics below:

YES ☐ NO ☐

Name of Medication	Disease-Disorder-Condition	How long have you been taking this medication?