



# Medicare Supplement Insurance Application Package



# Pennsylvania

Form: MS-APP PA 5-06

## **COMPLETING YOUR MEDICARE SUPPLEMENT APPLICATION:**

This packet contains the following forms needed to complete a Medicare Supplement application. Please review the following information and complete all needed forms:

- Application for Medicare Supplement (Form MS-APP PA 5-06). To be used only for Medicare Supplement applications.
- Agent Certification (Form MS-AC GN 5/06). This form must be signed by the agent and by the applicant (and spouse, if applying).
- Authorization for Release of Health-Related Information to Shenandoah Life Insurance Company (HIPAA form) (Form MS-5539 Rev. 7/06).
- Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage (Form MS-REPL PA 5/06). This form must be completed if any replacement is involved. One signed copy should be returned to the company, and one should be left with the applicant.

**Please note that you are also required to provide the applicant with the following items. You may order these items from Shenandoah Life by calling 1-800-848-5433, ext. 4320:**

- A Guide to Health Insurance for People with Medicare
- Outline of Coverage
- Insurance Information Practices (Summary is provided on page 6 of the application; more detailed information is available upon request.)

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**1. APPLICANT INFORMATION**

Proposed Insured			Spouse		
Name:			Name:		
Address:		Phone #: ( )	Address:		Phone #: ( )
City:	State:	Zip:	City:	State:	Zip:
Social Security #:	- -	DOB: / /	Social Security #:	- -	DOB: / /
Medicare #:	Sex:	Age:	Medicare #:	Sex:	Age:
Height*:	Weight*:		Height*:	Weight*:	
Have you used tobacco within the past 36 months?* YES <input type="checkbox"/> NO <input type="checkbox"/>			Have you used tobacco within the past 36 months?* YES <input type="checkbox"/> NO <input type="checkbox"/>		
Name & Address of family doctor:			Name & Address of family doctor:		
Proposed Effective Date:			Proposed Effective Date:		
Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent/Producer			Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent/Producer		

\* Do not complete if you are applying during an open enrollment or a guaranteed issue period.

**2. COVERAGE APPLIED FOR**

**MEDICARE SUPPLEMENT PLAN**

A  B  C  D  E  F  G

A  B  C  D  E  F  G

**3. PREMIUM INFORMATION**

**Proposed Insured:**

**1. Premium Information:**

a. Premium: \$ \_\_\_\_\_

Policy fee: \$ 25 per policy - One time

b. Premium Mode:  Monthly EFT  Annual  
 Quarterly  Semi-Annual

**Spouse:**

**1. Premium Information:**

a. Premium: \$ \_\_\_\_\_

Policy fee: \$ 25 per policy - One time

b. Premium Mode:  Monthly EFT  Annual  
 Quarterly  Semi-Annual

**4. BILLING INFORMATION**

1. Payment with Application: \$ \_\_\_\_\_ Payment by credit or debit card (*initial premium only*): \$ \_\_\_\_\_

Cardholder Name: \_\_\_\_\_

Card Type:  Visa  Mastercard Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_  
*mm/yy*

Billing Address of Cardholder: \_\_\_\_\_

Signature: \_\_\_\_\_

2. Premium notices sent to:  Proposed Insured  Other (*If Other is checked please provide information below.*)

Name: \_\_\_\_\_ Attention: \_\_\_\_\_

Relationship: \_\_\_\_\_

Social Security # or Tax ID #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**5. FOR MONTHLY EFT PREMIUMS ONLY**

I hereby authorize Shenandoah Life Insurance Company to make withdrawals each month from my account, indicated below, for the purpose of paying monthly premiums on any policy issued on this application.

**CHECK ONE:**

- Checking
- Savings

**For a Checking account, please attach a voided check.**

**For a Savings account, please complete the following information. Ask your financial institution to verify that this EFT will be accepted and that the information below is correct. This verification is necessary as not all financial institutions will acknowledge an EFT debit to a savings account.**

Financial Institution Name: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_ Transit Routing Number: \_\_\_\_\_

Depositor Address: \_\_\_\_\_ Depositor Account Number: \_\_\_\_\_

For policy effective dates of the 1st through the 10th, Shenandoah Life will draft on or about the 10th of each month. For policy effective dates of the 11th through the 20th, Shenandoah Life will draft on or about the 20th of each month. For policy effective dates of the 21st through the 28th, Shenandoah Life will draft on or about the 28th of each month.

I agree that the withdrawals on this account and financial institution shall constitute due notice of premiums being due upon the policy. The withdrawals reflected on my account statement will constitute a receipt. This authorization is revocable only upon receipt by Shenandoah Life Insurance Company of a written notice of revocation. 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 Shenandoah Life Insurance Company. A notification to stop EFT should be received by Shenandoah Life Insurance Company at least 10 days prior to the day of withdrawal.

\_\_\_\_\_  
Signature exactly as it appears on financial institution records

\_\_\_\_\_  
Print name of depositor, if other than proposed insured

\_\_\_\_\_  
Date

**6. MEDICAL AND GENERAL**

**Basic Questions (Answer for both Proposed Insureds)**

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.	<b>Proposed Insured</b>	<b>Spouse</b>
<b>To the best of your knowledge:</b>		
1. Did you turn 65 in the last 6 months?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
a. Did you enroll in Medicare Part B in the last 6 months?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. If yes, what is the effective date? Proposed Insured: _____ Spouse: _____		
2. Are you covered for medical assistance through the state Medicaid program?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>(If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.)</b>		
<b>If Yes,</b>		
a. Will Medicaid pay your premiums for this Medicare supplement policy?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. 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. Proposed Insured: START ___/___/___ END ___/___/___ Spouse: 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?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Was this your first time in this type of Medicare plan?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**6. MEDICAL AND GENERAL (Continued)**

**Basic Questions (Answer for both Proposed Insureds) (Continued)**

	<b>Proposed Insured</b>	<b>Spouse</b>
<p>4. a. Do you have another Medicare supplement policy in force?.....</p> <p>b. If so with what company? Proposed Insured: _____ Spouse: _____</p> <p>c. What plan do you have? Proposed Insured: _____ Spouse: _____</p> <p>d. If so, do you intend to replace your current Medicare supplement policy with this policy?.....</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<p>5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan).....</p> <p>a. If so, with what company? Proposed Insured: _____ Spouse: _____</p> <p>b. What kind of policy? Proposed Insured: _____ Spouse: _____</p> <p>c. What are your dates of coverage under the other policy? Insured: START ___/___/___ END ___/___/___ Spouse: START ___/___/___ END ___/___/___ (If you are still covered under the other policy, leave "END" blank.)</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Health Questions (Answer for both Proposed Insureds)**

	<b>Proposed Insured</b>	<b>Spouse</b>
<p><b>DO NOT ANSWER QUESTIONS 1-9 IF YOU ARE APPLYING FOR THIS COVERAGE WITHIN 6 MONTHS OF OBTAINING MEDICARE PART B, OR WITHIN A GUARANTEED ISSUE PERIOD. IF THE ANSWER TO ANY OF THE QUESTIONS 1-9 BELOW IS "YES", THE APPLICANT WILL NOT BE ELIGIBLE FOR COVERAGE. NOTICE TO APPLICANT: PLEASE VERIFY THE ACCURACY AND COMPLETENESS OF THE MEDICAL INFORMATION ON THIS APPLICATION. INCOMPLETE OR FALSE INFORMATION ON THIS APPLICATION COULD JEOPARDIZE FUTURE CLAIMS.</b></p>		
1. Are you bedridden or confined to a wheelchair?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past two years, have you been medically advised to have kidney dialysis?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Within the past two years, have you had or been medically advised or diagnosed by your physician that you had a heart attack, stroke or heart valve surgery?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Within the past two years, have you had, or been medically advised that you have, or been medically treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, Parkinson's Disease, disabling arthritis, degenerative bone disease, cirrhosis of the liver, Alzheimer's Disease or alcohol or drug abuse?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past two years, have you been medically recommended to have surgery for cataracts, joint replacement, a heart condition or other in-patient surgery but not had such surgery?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you had or been medically advised by your physician you have emphysema, chronic bronchitis, chronic obstructive pulmonary (COPD) or lung disease, or other chronic pulmonary disorder requiring the use of oxygen, myasthenia gravis, lupus, multiple or amyotrophic lateral sclerosis, paralysis, acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you had or been medically advised by your physician you needed amputation due to disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Are you an insulin dependent diabetic?.....	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

## 7. CERTIFICATION & AUTHORIZATION

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 policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy will 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, substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. 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 reinstated if requested within 90 days of losing your employer or union-based group health plan.

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

To the best of my knowledge and belief, all of the answers to the above questions are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company and the full first premium has been paid; 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 and agent acknowledge that the applicant has read, or had read to him, the completed application and that he realized 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.

**Authorization:** I hereby authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy or other medical or medically related facility, insurance company, other organization, institution or person, that has any records or knowledge of me, or my health, to give Shenandoah Life Insurance Company or its reinsurer(s) any such information. 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 Shenandoah Life Insurance Company. I understand that failure to provide the authorization to Shenandoah Life Insurance Company *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 Shenandoah Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10855, Clearwater, Florida 33757-8855. I understand that such revocation will not have any effect on actions Shenandoah Life Insurance Company 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, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy.

Medical information will not be used to decline coverage if you are applying during an open enrollment or guaranteed issue period.

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

I acknowledge receiving: (a) "A Guide to Health Insurance for People with Medicare", (b) Outline of Coverage; and (c) Insurance Information Practices Notice.

Signed at \_\_\_\_\_ (City) \_\_\_\_\_ (State) \_\_\_\_\_ (Month/Day) \_\_\_\_\_ (Year)

\_\_\_\_\_  
(Applicant's Signature)

\_\_\_\_\_  
(Spouse's Signature if applying for coverage)

**8. OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION**

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-9 on Page 3 of this application if you are within 6 months of purchasing Medicare Part B coverage for the first time.

**Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:**

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization’s certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization’s certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material certificate/policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement certificate/policy and coverage discontinues due to insolvency, substantial violation of a material certificate/policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement certificate/policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A and enrolled in Part B, if eligible, enrolled in a Medicare Advantage or PACE provider and you disenroll within 12 months; or
- (g) Terminated coverage under a Medicare Supplement policy that covers outpatient prescription drugs and enrolled in a Medicare Part D plan during the initial enrollment period.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

**9. AGENT CERTIFICATION**

The undersigned Agent certifies that the Applicant(s) has read, or had read to him/her, the completed application and that the Applicant(s) realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy. AGENT COMPLETES (attach separate sheet, if necessary.)

**TO AGENT:** List all Health Insurance Policies sold to the applicant(s) which are still in force.

COMPANY \_\_\_\_\_ TYPE \_\_\_\_\_

List all Health Insurance Policies sold to the applicant(s) within the past 5 years which are no longer in force.

COMPANY \_\_\_\_\_ TYPE \_\_\_\_\_

**I certify:** (1) I have accurately recorded the information supplied by the Applicant(s); (2) I have given an outline of coverage for the policy applied for and a “A Guide to Health Insurance for People with Medicare” to the Applicant(s).

Agent’s Name (Please Print) \_\_\_\_\_ Agent’s Signature \_\_\_\_\_

Agent Code No. \_\_\_\_\_ State License # \_\_\_\_\_

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**INITIAL PREMIUM RECEIPT**

MAKE CHECK PAYABLE TO: SHENANDOAH LIFE INSURANCE COMPANY

Received from \_\_\_\_\_ (Applicant) an application for a Medicare Supplement Policy with Shenandoah Life Insurance Company, Roanoke, Virginia and \$ \_\_\_\_\_ for the initial premium. In the event that the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its home office and a policy is issued.

Date \_\_\_\_\_ Agent \_\_\_\_\_

**INSURANCE INFORMATION PRACTICES**

1. Personal information may be collected from persons other than the individual or individuals proposed for coverage.
2. Such information, as well as other personal or privileged information subsequently collected, may be disclosed to third parties in certain circumstances, without authorization.
3. A right of access and correction exists with respect to all personal information collected.
4. A more complete notice describing our information practices in detail will be furnished to you upon request.

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**AGENT CERTIFICATION**

I the undersigned insurance agent certify:

**THAT**, I have taken an application for

Medicare Supplement (A-G)

**Primary Insured:**

- |                                 |                                 |
|---------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan E |
| <input type="checkbox"/> Plan B | <input type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan G |
| <input type="checkbox"/> Plan D |                                 |

**Spouse:**

- |                                 |                                 |
|---------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan E |
| <input type="checkbox"/> Plan B | <input type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan G |
| <input type="checkbox"/> Plan D |                                 |

offered by **SHENANDOAH LIFE INSURANCE COMPANY**,

to \_\_\_\_\_ (Applicant),

**THAT**, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

**THAT**, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of \$ \_\_\_\_\_ (Insert zero if no premium received) which has been paid to me by

Check     Cash     Money Order     Credit/Debit Card    *(Check appropriate method of payment).*

**THAT**, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

**THAT**, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

\_\_\_\_\_  
Name of Agency

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Address of Agent or Agency

\_\_\_\_\_  
Signature of Spouse, if applying

\_\_\_\_\_  
Phone Number



AUTHORIZATION FOR RELEASE OF HEALTH-RELATED INFORMATION TO SHENANDOAH LIFE INSURANCE COMPANY

THIS AUTHORIZATION COMPLIES WITH THE HIPAA PRIVACY RULE

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, or other health care provider that has provided payment, treatment or services on my behalf within the past 10 years ("Providers") to disclose the entire medical record and any other protected health information concerning me to Shenandoah Life Insurance Company and its agents, employees, and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes psychotherapy notes.

By my signature below, I acknowledge that any agreements made to restrict such protected health information do not apply to this Authorization, and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose such entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Shenandoah Life Insurance Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage that I have applied for with Shenandoah Life Insurance Company.

This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. Except I understand that if I reside in Arizona, as to HIV-related information only this Authorization shall remain valid for 180 days. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to Shenandoah Life Insurance Company at P.O. Box 10853, Clearwater, FL 33757-8853. I understand that a revocation is not effective to the extent that any of the Providers has relied on this Authorization or to the extent that Shenandoah Life Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this Authorization to release the complete medical record, Shenandoah Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

\_\_\_\_\_  
Name of Proposed Insured (please print) \_\_\_\_\_ Date \_\_\_\_\_

X \_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Name of Proposed Insured (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
**TO BE COMPLETED BY AGENT OR HOME OFFICE ONLY**



**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE**

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by Shenandoah Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

**STATEMENT TO APPLICANT BY ISSUER, AGENT**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- \_\_\_\_\_ Additional benefits
- \_\_\_\_\_ No change in benefits, but lower premiums.
- \_\_\_\_\_ Fewer benefits and lower premiums.
- \_\_\_\_\_ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- \_\_\_\_\_ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. \_\_\_\_\_
- \_\_\_\_\_ Other. (Please Specify) \_\_\_\_\_

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

\_\_\_\_\_  
Signature of Agent, Broker or other Representative      PRINTED Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Applicant's Signature      Signature of Spouse, if applying

\_\_\_\_\_  
Date

**RETURN TO COMPANY**

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**STATEMENT TO APPLICANT BY ISSUER, AGENT**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. \_\_\_\_\_
- Other. (Please Specify) \_\_\_\_\_

If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

**Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

\_\_\_\_\_  
Signature of Agent, Broker or other Representative      PRINTED Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Applicant's Signature      Signature of Spouse, if applying

\_\_\_\_\_  
Date

LEAVE WITH APPLICANT

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