

# Company Name Medicare Supplement Coverage Quote Form

You may complete this form and send it to us using our secure server by clicking on the "Submit" button below or you may fill in the information, print the form from your browser window by clicking "Print Page" button above and mail or fax the form to:



**Company Name**  
Company Address  
City, State, Zip  
Tel. (555) 555-5555  
Fax (555) 555-5555  
www.domain.com

\* Denotes Required Field

## General Information

\*Name:

\*Address:

\*City:

\*State:

\*Zip Code:

\*Day Phone:

\*Evening Phone:

Ex: 920-111-2222

Best Time to Call:

\*E-Mail Address:

\*Confirm E-Mail Address:

## Personal Information

\*Date of Birth:

Ex.01/12/2007

Age:

Sex:

Height:

ft.

in.

Weight:

lbs.

Are you a U.S. citizen?

If "No," do you have an Alien Registration Receipt Card?

ARR Card #:

U.S. Arrival Date:

Ex:01/12/2007

## Current Medicare Information

Are you covered under Medicare "Part A"?

If "No," when will you become eligible?

Ex: 01/12/2007

Are you covered under Medicare "Part B"?

If "No," when will you become eligible?

Ex. 01/12/2007

## Health Questions

If you are applying for coverage during open enrollment or during a guaranteed issue period, you **do not** need to answer the following questions. Please move to the section entitled "Additional Health Questions."

Are you currently hospitalized or confined to a nursing facility, or are you bedridden or confined to a wheel chair?

Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), or other chronic pulmonary disorders?

Do you have Parkinson's Disease, or either multiple or lateral sclerosis?

Have you been diagnosed with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder?

Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?

Do you have kidney disease requiring dialysis or diabetes requiring more than 50 units of insulin on a daily basis?

Within the past two years, have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism and/or drug abuse, cirrhosis, a mental or nervous disorder requiring psychiatric care, or have you had any amputation as a result of disease?

Within the past two years, have you been treated for or been advised by a physician to have treatment for heart, coronary or carotid artery disease (*not including high blood pressure*), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA), or heart rhythm disorders?

Within the past two years, have you been treated for osteoporosis, degenerative bone disease, or crippling arthritis?

Have you been advised that surgery may be required within the next 12 months for cataracts?

Have you been advised to have surgery or medical tests that have not yet been performed?

Have you been confined to a hospital three or more times in the last two years?

### Additional Health Questions

Have you used tobacco in any form within the past 12 months?

Are you taking or have you taken any prescription or over-the-counter medication within the past 12 months?

*If you answered "Yes," please list the medication details below:*

Medication Name: <i>(copy off pharmacy label)</i>	Dosage:	Frequency:	Reason:
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*Please list any additional medications in the "Additional Comments" section at the bottom of this form*

### Additional Medicare Questions

Do you have another Medicare supplement insurance policy or certificate in force?

If "Yes," do you intend to replace you current Medicare supplement policy or certificate with this policy?

If "Yes," please indicate the termination date: *Ex. 01/12/2007*

*Are you covered for medical assistance through the state Medicaid program:*

As a Specified Low Income Medicare Beneficiary (SLMB)?

As a Qualified Medicare Beneficiary (QMB)?

For other Medicaid medical benefits?

## Additional Comments

Please provide any additional comments that you feel would be appropriate for this quotation. If you have additional information to provide, where there were not enough fields above; please enter it here:

### \*Acknowledgement and Consent

I hereby certify that the above information is complete and accurate to the best of my knowledge. The agency receiving this application will retain the application whether or not a policy is issued. The agency may rely on this application when determining the quotation and when deciding whether to issue a policy. False statements may subject me to criminal penalties.

If a policy is issued, I authorize the agency to give information about me to its affiliates.

**Yes    No**

**\*Enter Your Initials Here:**

**\*Today's Date:**

Ex: 01/12/2007

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