i. (1) Did you turn 65 in the last 6 months?

(A) Yes ______________No ______________

(2) Did you enroll in Medicare Part B in the last 6 months?

(A) Yes ______________No ______________

(3) If yes, what is the effective date?

(A) ____

ii. Are you covered for medical assistance through the State Medicaid program? (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.)

(1) Yes ______________No ______________ If yes

(A) Will Medicaid pay your premiums for this Medicare supplement policy?

(B) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

iii. (1) 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.

(A) START ______________/______________/______________ END ______________/______________/______________

(2) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?

(A) Yes ______________No ______________

(3) Was this your first time in this type of Medicare plan?

(A) Yes ______________No ______________

(4) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

(A) Yes ______________No ______________

iv. (1) Do you have another Medicare supplement policy in force?

(A) Yes ______________No ______________

(2) If so, with what company, and what plan do you have (optional for Direct Mailers)?

(A)____

____

(3) If so, do you intend to replace your current Medicare supplement policy with this policy?

(A) Yes ______________No ______________

v. (1) Have you had coverage under any other health insurance plan within the last 63 days?

(A) Yes ______________No ______________

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

(A)____

____

(3) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

(A) START ______________/______________/______________ END ______________/______________/______________