Transamerica Premier Application Packet

Thank you for your interest in applying for the Transamerica Premier Life Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Transamerica Premier Life. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-idaho.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Transamerica Premier Life Insurance Company
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Medicare Supplement

A. Please answer all questions completely. ONLY complete the Applicant B information if a second individual is applying for coverage.

APPLICANT A	APPLICANT B
1. Name (First,MI,Last)	1. Name (First,MI,Last)
2. Residence Address (Cannot be a P.O. Box)	2. Residence Address (Cannot be a P.O. Box)
3. City	3. City
4. State Zip	4. State Zip
5. Mailing Address (If different from residence address)	5. Mailing Address (If different from residence address)
6. City	6. City
7. State Zip	7. State Zip
8. Phone Number ( )	8. Phone Number ( )
9. Best time to call for a Personal History Interview _____a.m. _____p.m.	9. Best time to call for a Personal History Interview _____a.m. _____p.m.
10. Current Age Date of Birth (MM/DD/YYYY)	10. Current Age Date of Birth (MM/DD/YYYY)
11. ☐ Male U.S. State/Country of Birth ☐ Female	11. ☐ Male U.S. State/Country of Birth ☐ Female
12. Social Security Number	12. Social Security Number
13. Medicare Health Insurance Card Number	13. Medicare Health Insurance Card Number
14. Occupation	14. Occupation
15. E-mail Address	15. E-mail Address
16. Height Ft._____ In._____ Weight Lbs._____	16. Height Ft._____ In._____ Weight Lbs._____
17. Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No	17. Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No
18. Secondary Addressee: A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage. Name (First, MI, Last)	18. Secondary Addressee: A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage. Name (First, MI, Last)
Address	Address
City, State, Zip	City, State, Zip
Phone Number	Phone Number

B. Plan Information (to be completed by Agent)

APPLICANT A	APPLICANT B
1. Medicare Supplement Plan _____	1. Medicare Supplement Plan _____
2. Requested Effective Date	2. Requested Effective Date
3. Mail Policy To: ☐ Owner ☐ Agent	3. Mail Policy To: ☐ Owner ☐ Agent
4. Have you ever been declined or denied reinstatement for Medicare Supplement? ☐ Yes ☐ No If "YES," when and why?	4. Have you ever been declined or denied reinstatement for Medicare Supplement? ☐ Yes ☐ No If "YES," when and why?

C. Premium & Payment Method (must be completed)

1. Medicare Supplement Premium $_____	1. Medicare Supplement Premium $_____
2. Medicare Supplement One-Time Application Fee $ 25.00	2. Medicare Supplement One-Time Application Fee $ 25.00
3. Total Initial Premium $_____	3. Total Initial Premium $_____
4. Mode of Payment: ☐ EFT ☐ Direct Bill ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (EFT Only)	4. Mode of Payment: ☐ EFT ☐ Direct Bill ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (EFT Only)

D. Please answer all of the following questions.

	APPLICANT A	APPLICANT B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage?**	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you eligible for Medicare due to disability?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," are you disabled due to End Stage Renal Disease?	☐ Yes ☐ No	☐ Yes ☐ No
To the Best of Your Knowledge:		
3. Are you covered under Medicare Part A?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part A effective date? _____ (Applicant A) _____ (Applicant B)		
If "NO," what is your eligibility date? _____ (Applicant A) _____ (Applicant B)		
4. Are you covered under Medicare Part B?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part B effective date? _____ (Applicant A) _____ (Applicant B)		
If "NO," indicate date you plan to enroll. _____ (Applicant A) _____ (Applicant B)		
5. Are you applying during a guaranteed issue or open enrollment period? (NOTE: If the answer above is "YES," please attach proof of eligibility and DO NOT complete section F.)	☐ Yes ☐ No	☐ Yes ☐ No

E. FOR YOUR PROTECTION, we ask the following questions about insurance policies or certificates you may have.

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 certificate, or that you had certain rights to buy such a policy or certificate, 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 BELOW. Please mark "YES" or "NO" with an "X" to the questions below.**

To the Best of Your Knowledge:	APPLICANT A	APPLICANT B
1. Did you turn age 65 in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," indicate your effective date. _____ (Applicant A) / _____ (Applicant B)		
3. 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.)	☐ Yes ☐ No	☐ Yes ☐ No
If "YES,"		
a. Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No	☐ Yes ☐ No
b. Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	☐ Yes ☐ No	☐ Yes ☐ No

If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #5.	**APPLICANT A**	**APPLICANT B**
4. 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 _____ / START _____ END _____ (Applicant A / Applicant B)		
a. 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	☐ Yes ☐ No
b. **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No
c. Reason for termination/disenrollment? _____ / _____ (Applicant A / Applicant B)		
d. Planned date of termination/disenrollment? _____ / _____ (Applicant A / Applicant B)		
e. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
f. Did you drop a Medicare Supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
g. Is your former Medicare Supplement or Medicare Select policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No
5. Do you have another Medicare Supplement or Medicare Select policy/certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
a. If "YES," with what company, and what plan do you have?		

APPLICANT A	**APPLICANT B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date (MM/DD/YYYY)	Issue Date (MM/DD/YYYY)

	APPLICANT A	**APPLICANT B**
b. If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
c. If "YES," indicate termination date. _____ / _____ (Applicant A / Applicant B)		
d. **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual non-Medicare Supplement plan) a. If "YES," with what company and what kind of policy/certificate? (List below)	☐ Yes ☐ No	☐ Yes ☐ No

APPLICANT A		**APPLICANT B**	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

b. What are your dates of coverage under the other policy/certificate? (If you are still covered under this plan, leave "END" blank.)

START _____ END _____ / START _____ END _____ (Applicant A / Applicant B)

c. Reason for termination/disenrollment? _____ / _____ (Applicant A / Applicant B)

d. Planned date of termination/disenrollment? _____ / _____ (Applicant A / Applicant B)

7. Agents shall list any other health insurance policies/certificates they have sold to the Applicant.
   a. List policies/certificates sold which are still in force.

APPLICANT A	APPLICANT B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage (MM/DD/YYYY)	Effective Date of Coverage (MM/DD/YYYY)

   b. List policies/certificates sold in the past five (5) years which are no longer in force.

APPLICANT A	APPLICANT B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage (MM/DD/YYYY)	Effective Date of Coverage (MM/DD/YYYY)

F. Personal History Questions - Complete this section only if you are NOT applying during a guaranteed issue period.

1. Have you been prescribed or taken any prescription medications within the past 12 months? If "YES," please indicate below. If "NO," indicate "None." Agent - This is to assist in preparing the Applicant to answer questions in sections 3 through 5.

APPLICANT A Name of Medication, Date Prescribed and Condition *(Example: Vytorin, 10/2009, High Cholesterol)*	APPLICANT B Name of Medication, Date Prescribed and Condition *(Example: Vytorin, 10/2009, High Cholesterol)*

	APPLICANT A	APPLICANT B
2. Have you within the past 10 years been diagnosed with diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you within the past 10 years:		
a. been advised by a physician to have or are you currently waiting for an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
b. been diagnosed with, treated, or advised to receive treatment for Alzheimer's Disease, dementia, mental incapacity, organic brain disease or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. been diagnosed with, treated or advised to receive treatment for Lou Gehrig's disease (ALS), Huntington's disease or any terminal medical condition?	☐ Yes ☐ No	☐ Yes ☐ No
d. been diagnosed with, treated or advised by a licensed member of the medical profession to receive treatment for Systemic Lupus, Osteoporosis with Fractures, or kidney disease or failure requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
e. used insulin to treat or control diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
f. had any type of Diabetes with Complications including retinopathy, neuropathy, nephropathy, peripheral vascular disease, heart disease, stroke, transient ischemic attack (TIA), high blood pressure, or skin ulcers?	☐ Yes ☐ No	☐ Yes ☐ No
g. been in a diabetic coma or had or been advised to have an amputation due to disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No
h. been diagnosed with, treated or advised to receive treatment for Cirrhosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	☐ Yes ☐ No	☐ Yes ☐ No
i. tested positive for the antibodies to the AIDS (HIV) virus or been diagnosed with, treated, or advised to receive treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No

	APPLICANT A	APPLICANT B
j. been diagnosed, treated or advised to receive treatment for any neurological disease or disorder such as Myasthenia Gravis, Multiple or Lateral Sclerosis, or Parkinson's disease?	☐ Yes ☐ No	☐ Yes ☐ No
4. Within the past 2 years have you:		
a. been advised to or do you currently use a wheelchair?	☐ Yes ☐ No	☐ Yes ☐ No
b. been advised to enter or do you reside in a nursing home, assisted living facility, long term care facility, received hospice, attended an adult day care facility, required home health care, or been bedridden?	☐ Yes ☐ No	☐ Yes ☐ No
c. been admitted to a hospital 3 or more times or are you currently admitted to a hospital?	☐ Yes ☐ No	☐ Yes ☐ No
d. been diagnosed, treated or advised to receive treatment for cancer (other than basal cell carcinoma)?	☐ Yes ☐ No	☐ Yes ☐ No
e. been diagnosed, treated or advised to receive treatment for alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care?	☐ Yes ☐ No	☐ Yes ☐ No
f. been diagnosed, treated or advised to receive treatment for heart attack, 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?	☐ Yes ☐ No	☐ Yes ☐ No
g. been diagnosed, treated or advised to receive treatment for degenerative bone disease impacting multiple joints, crippling/disabling or rheumatoid arthritis or been advised to have a joint replacement?	☐ Yes ☐ No	☐ Yes ☐ No
h. been advised to have surgery, medical tests, treatment or therapy that has not yet been performed or undergone testing by a medical professional for which the results have not yet been received?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts or have you used or been advised to use oxygen equipment, respirator or a catheter?	☐ Yes ☐ No	☐ Yes ☐ No

If any question in 3, 4 and 5 is answered "YES," please STOP. The Applicant is NOT eligible for underwritten Medicare Supplement.

G. Billing Information

I would like my monthly direct payment to come from my account below (check one) on the ____ day of the month (1st-28th):

☐ Checking **Please attach a voided check** ☐ Savings **Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.**

Financial Institution Name:	Phone Number:
Financial Institution Address:	
Transit Routing Number:	Account Number:

I hereby request and authorize Transamerica Premier Life Insurance Company to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after that first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Transamerica Premier Life Insurance Company or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Transamerica Premier Life Insurance Company's rights in respect to each charge shall be the same as if it were a check made payable to Transamerica Premier Life Insurance Company and personally signed by me. If any charge is dishonored for any reason, Transamerica Premier Life Insurance Company shall not be under any liability even though such dishonor results in the forfeiture of insurance.

Signature as it appears on financial institution records

Print name of account owner (if other than Applicant)

Date

If the EFT premium payment method is chosen, please tape a voided check in this box.
NO 3rd PARTY CHECKS PLEASE

H. Please Read and Sign Below

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- 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 can 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, a substantially equivalent policy) will be reinstituted if requested with 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).
- Idaho Department of Insurance, Consumer Affairs, 700 West State Street, 3rd Floor, PO Box 83720, Boise ID, 83720-0043. 1-800-721-3272, 208-334-4250 or www.DOI.Idaho.gov

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgement will be valid for 24 months after it is signed. I acknowledge and agree that this application and any amendments shall be the basis for any insurance issued and that the agent does not have the authority to waive any question on this application.

If I am applying for a Medicare supplement insurance policy, I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each Applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Transamerica Premier Life Insurance Company.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Dated at _____ , on _____ , _____ _____
City State Month Day Year Applicant A's Signature

Dated at _____ , on _____ , _____ _____
City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed Applicant, I/we have truly and accurately recorded in the application the information supplied by the Applicant.

_____ Tiffany Jackson
(Signature of Licensed Agent) (Print Agent Name)

1205054
Agent Number / (Stamp)

Transamerica Premier Life Insurance Company
Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

Supplemental Information for Life or Health Insurance

Proposed Primary Insured Name:_____ Social Security Number: _____

ADDITIONAL INFORMATION

Question Number	Name of Proposed Insured	Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers

ADDITIONAL INFORMATION

Dated at _____ (City) _____ (State) this _____ day of _____ (Month), _____ (Year)

_____
Signature of Proposed Insured

_____
Signature of Proposed Owner (if other than Proposed Insured)

_____
Signature of Parent or Legal Guardian (if Proposed Insured is Under 18 years of age)

_____
Signature of Additional Insured

_____
Signature of Agent/Registered Rep/Witness/Vendor Rep

SA-ADINFO 0914

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, IA 52499
Administrative Office:
4333 Edgewood Rd NE
Cedar Rapids, IA 52499
(800) 322-7164

ADDENDUM TO APPLICATION

PRE-EXISTING CONDITION LIMITATION

I hereby apply for Individual Medicare Supplement coverage issued by Transamerica Premier Life Insurance Company. I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months prior to the effective date until I have been insured for 6 consecutive months. If this plan replaces creditable coverage, such as Medicare Supplement Insurance or primary Hospital and medical reimbursement coverage that has been in force within the past 63 days, then this pre-existing condition limitation will be waived to the extent it was satisfied under the replaced coverage.

A copy of this Addendum, identical to the form filed, will be printed and made part of your application.

I represent that the statements in this Addendum are true, complete and correctly recorded. It is agreed that information in this Addendum shall be used as the basis for any policy issued.

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant A's Signature

Dated at _____, on _____, _____ _____
City State Month Day Year Applicant B's Signature (if applying)

_____ Date_____
Signature of Licensed Agent

CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

Conditions of Coverage

1. On the Effective date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;

2. An amount equal to the first full premium required is paid during the lifetime of all persons proposed for coverage and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented; and,

3. For Life Insurance – Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under all applicable Company underwriting standards for the plan and for the amount applied for, without modification of plan, premium of rates, or amount of coverage; or

For Medicare Supplement Insurance – The person applying for coverage has had his/her application accepted by the Company under its underwriting standards and applicable Company rules for the Medicare Supplement Plan applied for.

Effective Date

For Life Insurance – If all of the above conditions are met, insurance in the amount applied for or $25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

For Medicare Supplement Insurance – If all of the applicable conditions here are met, the Medicare Supplement Plan applied for will become effective on the date stated on the Policy Schedule Page. If any of these conditions are not met, coverage will not take effect and the liability of the Company is the return of any amount paid by the applicant.

MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Transamerica Premier Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Premier Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

OPEN ENROLLMENT AND GUARANTEED ISSUE WORKSHEET

If any of the following situations apply, applicant is in an open enrollment or guaranteed issue period:
(Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

ELIGIBILITY FOR OPEN ENROLLMENT

Applicant is:

- at least 64½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

Note: Coverage cannot be effective until your Medicare coverage is effective.

ELIGIBILITY FOR GUARANTEED ISSUE

Evidence of eligibility is required for the following situations.
Applicant:

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy a Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Applicant was enrolled in a Medicare Advantage (MA) plan, and:

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

Applicant has the right to buy a Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

Applicant has the right to buy a Medicare supplement plan that is sold in the applicant's state by any insurance company.

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

Applicant has the right to buy a Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.

Acceptable Evidence of Eligibility:

a. Copy of the applicant's MA plan's termination notice
b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
d. Certification of group coverage
e. Copy of the termination letter from employer or group carrier
f. Image of insurance ID card (ONLY allowed if your MA plan is being terminated)

RESET

Transamerica Premier Life Insurance Company
4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

Signature of Primary Proposed Insured/Patient or Personal Representative	Date
Signature of Secondary Proposed Insured/Patient or Personal Representative	Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

☐ Parent ☐ Legal guardian ☐ Power of Attorney ☐ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

Transamerica Premier Life Insurance Company
4333 Edgewood Road NE, Cedar Rapids, IA 52499

HIPAA Authorization for Release of Health-Related Information

This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Name of Primary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name of Secondary Proposed Insured/Patient	Date of birth	Last four digits of SSN
Name(s) of Unemancipated Minors	Date(s) of birth	Last four digits of SSN(s)

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:

☐ Parent ☐ Legal guardian ☐ Power of Attorney ☐ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

A copy of this authorization will be considered as valid as the original.

Notice To Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, IA 52499
Administrative Office: 4333 Edgewood Rd. NE, Cedar Rapids, Iowa 52499

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with the enclosed Medicare Supplement coverage issued by Transamerica Premier 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 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, Broker or other Representative:

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*)_____

1. Health conditions which you may presently have may not be immediately or fully covered under the new Medicare Supplement coverage. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement coverage may not contain new waiting periods, elimination periods or probationary periods. We will waive any time periods applicable to waiting periods, elimination periods or probationary periods in your new coverage for similar benefits to the extent such time was spent under your original coverage.

3. 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, if any. 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 you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)

_____

(Applicant's Signature)

_____

(Date)

Notice To Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Transamerica Premier Life Insurance Company
Home Office: Cedar Rapids, IA 52499
Administrative Office: 4333 Edgewood Rd. NE, Cedar Rapids, Iowa 52499

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According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with the enclosed Medicare Supplement coverage issued by Transamerica Premier 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 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, Broker or other Representative:

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*)_____

1. Health conditions which you may presently have may not be immediately or fully covered under the new Medicare Supplement coverage. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present coverage.

2. State law provides that your replacement coverage may not contain new waiting periods, elimination periods or probationary periods. We will waive any time periods applicable to waiting periods, elimination periods or probationary periods in your new coverage for similar benefits to the extent such time was spent under your original coverage.

3. 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, if any. 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 you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)

_____

(Applicant's Signature)

_____

(Date)