Cigna Medicare Supplement Insurance
Cigna National Health Insurance Company

APPLICATION BOOKLET FOR KENTUCKY

This packet contains all required forms for application submission. Please complete each form according to the instructions on each page.

- Application
- Electronic funds transfer agreement(s)
- HIPAA notices
- Replacement notice(s)

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 7 a.m. to 7 p.m. Central Time.**

Together, all the way.®

Cigna®

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

Cigna National Health Insurance Company
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272 • www.Cigna.com
Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186

Application is for: ☐ New business ☐ Reinstatement Phone verification case #(s) _____

› If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.

› If only one Applicant, complete Applicant A questions.

A. Personal information

Applicant A

Name *(First MI Last)* | **Age** | **Date of birth** *(MM/DD/YYYY)* | **Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* | **Phone** ( )

Mailing address *(if different from resident address)* | **Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically.*

Applicant B

Name *(First MI Last)* | **Age** | **Date of birth** *(MM/DD/YYYY)* | **Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* – OR check box ❑ if same as Applicant A | **Phone** ( )

Mailing address *(if different from resident address)* | **Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically.*

Premium discount (see Outline of Coverage for details)

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
1. a. Do you live with someone 18 years or older (6% premium discount)?	☐	☐	☐	☐
b. If YES, do they have a Medicare Supplement policy with Cigna National Health Insurance Company or an affiliate of Cigna National Health Insurance Company (20% total premium discount)?	☐	☐	☐	☐

2. If you answered YES to 1b, please provide member information if other than Applicant A or Applicant B.

Name *(First MI Last)* | **Social Security no.** *(XXX-XX-XXXX)*

B. Please provide your Medicare information *(as shown on your Medicare card)*

Applicant A
Medicare number _____
Hospital (Part A) coverage starts *(MM/DD/YYYY)* _____
Medical (Part B) coverage starts *(MM/DD/YYYY)* _____

Applicant B
Medicare number _____
Hospital (Part A) coverage starts *(MM/DD/YYYY)* _____
Medical (Part B) coverage starts *(MM/DD/YYYY)* _____

You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

C. Select a plan and effective date

Applicant A Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N

Applicant B Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N

Requested Medicare Supplement effective date *(MM/DD/YYYY)* **A** _____ **B** _____

(if no effective date is requested, we will assign the 1st day of the month following the date of this application)

*Plan F is only available if you are first Medicare-eligible before 2020.

D. Are you eligible for Open Enrollment or Guaranteed Issue?

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 *(mark* YES *or* NO *below with an* "X"*)*.

To the best of your knowledge:

		Applicant A		Applicant B	
		YES	NO	YES	NO
1.	a. Did you turn age 65 or become eligible for Medicare due to a disability in the last six (6) months?	☐	☐	☐	☐
	b. Did you enroll in Medicare Part B in the last six (6) months?	☐	☐	☐	☐
	If YES, what is the effective date? *(MM/DD/YYYY)* **A**_____ **B**_____				
2.	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.)	☐	☐	☐	☐
	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?	☐	☐	☐	☐
3.	Have 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)?	☐	☐	☐	☐
	If YES,				
	a. fill in your START and END dates below *(if you are still covered under this plan, leave the END date blank)*.				
	A START _____ END _____				
	B 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?	☐	☐	☐	☐
	c. was this your first time in this type of Medicare plan?	☐	☐	☐	☐
	d. did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐	☐	☐	☐
4.	a. Do you have another Medicare Supplement policy in force?	☐	☐	☐	☐
	b. If so, with what company and what type plan do you have?				
	A _____				
	B _____				
	c. If so, do you intend to replace your current Medicare Supplement policy with this policy? If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.	☐	☐	☐	☐
5.	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?				
	A _____				
	B _____				
	b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave the END date blank.)*				
	A START _____ END _____				
	B START _____ END _____				

E. Complete medical questions

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) B & D), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage.

		APPLICANT A		APPLICANT B	
		YES	NO	YES	NO
1.	Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	☐	☐	☐	☐
2.	Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	☐	☐	☐	☐
3.	Do you have a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	☐	☐	☐	☐
4.	Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐	☐	☐
5.	Within the past six (6) months, have you been treated for or advised by a medical professional to have treatment for diabetes with hypertension that required three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	☐	☐	☐	☐
6.	Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • heart attack, congestive heart failure, coronary bypass, or stroke? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases).)	☐	☐	☐	☐
7.	At any time, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)? • Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis? • chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, cirrhosis of the liver or any condition requiring an organ transplant? • bipolar disorder, schizophrenia, a paranoid disorder, severe depression, or treatment for depression with medication for two (2) or more years? • organic brain disorder? • Alzheimer's disease? • unrepaired aneurysm, hemophilia, or any other blood disorder? • any heart disease requiring a permanent, implantable cardiac defibrillator?	☐	☐	☐	☐
8.	Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following: • any cancer, excluding skin cancer (except malignant melanoma)? • anemia requiring repeated blood transfusions? • alcohol or drug abuse (including counseling)? • pancreatitis? • seizure?	☐	☐	☐	☐
9.	At any time, have you been treated for or advised by a medical professional to have treatment for an amputation caused by disease or for an organ transplant (other than corneas)?	☐	☐	☐	☐
10.	Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	☐	☐	☐	☐
11.	Have you ever had a positive test result for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	☐	☐	☐	☐

If you answered NO to all questions in this Section, please continue to Part B. >>>

E. Complete medical questions *(cont'd.)*

PART B. MEDICAL QUESTIONS AND MEDICATIONS – The answers to questions in Part B are subject to the Company's underwriting review and may result in a decline. Please provide complete details as requested.

12. **Applicant A** Height *(ft.-in.)* _____ Weight *(lbs.)* _____
    Applicant B Height *(ft.-in.)* _____ Weight *(lbs.)* _____

	Applicant A		Applicant B	
	YES	NO	YES	NO
13. a. Have you used tobacco within the last 12 months?	☐	☐	☐	☐
b. If YES, do you currently have a heart condition, vascular condition, or diabetes?	☐	☐	☐	☐
14. In the last two (2) years, have you been treated for or advised by a medical professional to have treatment for any of the following:	☐	☐	☐	☐
• angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, transient ischemic attack (TIA)? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases).)				
15. At any time, have you been treated for or advised by a medical professional to have treatment for any of the following:				
• chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or other chronic lung or respiratory disorder not listed that requires the permanent use of oxygen?	☐	☐	☐	☐
• diabetes with neuropathy, diabetes with retinopathy, or diabetes with vascular disease?	☐	☐	☐	☐
• cerebral palsy, myasthenia gravis, systemic lupus, or Parkinson's disease?	☐	☐	☐	☐
• hepatitis other than hepatitis A, or other liver disease?	☐	☐	☐	☐
• dementia or senility?	☐	☐	☐	☐
• PSA levels greater than 6.0?	☐	☐	☐	☐

16. Please list any prescription medications taken or prescribed in the past two (2) years *(attach a separate sheet if needed)*.

Medication name	Dates taken	Reason for medication
Applicant A		
Applicant B		

F. Important statements for Applicant to read

- 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 within 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).
- You are eligible for a new "open enrollment" period, referred to as the "Birthday Rule", if you satisfy all of the following requirements:
  - Insured under a Medicare supplement policy.
  - Your application is submitted to a different insurer than the insurer that issued your current Medicare supplement policy.
  - You apply for the same plan and within sixty (60) days of your birthday.

I hereby apply to Cigna National Health Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Applicant A Telephone number (_____) _____ Best time to call _____

Applicant B Telephone number (_____) _____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

Applicant A Signature _____ Date _____

Applicant B Signature _____ Date _____

G. Determine your rate class

A	B		
☐	☐	**Preferred**	If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, questions 13a, 14, and 15.
☐	☐	**Standard**	If you answered YES to section E, question 13a (tobacco use), and NO to questions 13b, 14, and 15.
☐	☐	**Standard II**	If you answered NO to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.
☐	☐	**Standard III**	If you answered YES to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.

Your eligibility for coverage and final rate class is subject to underwriting review. Medications and height and weight impact your rate class. Please refer to the declinable drug list and height and weight chart for guidance.

H. Choose your method of payment

Applicant A
Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*

☐ Direct bill *(enclose check payable to* **Cigna National Health Insurance Company***; do not send cash)*

Mode: ☐ Monthly *(bank draft)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $_____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.
If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.80.

Applicant B
Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*

☐ Direct bill *(enclose check payable to* **Cigna National Health Insurance Company***; do not send cash)*

Mode: ☐ Monthly *(bank draft)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $_____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.
If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.80.

I. Agent use only

Please answer all questions:

1. List policies sold which are still in force *(if this does not apply, state "NONE")*._____
   _____
2. List policies sold in the past five (5) years which are no longer in force *(if this does not apply, state "NONE")*. _____
   _____
3. I certify that I have provided the Applicant(s) with the following documents:
   a. Application packet *(phone sales only)* b. *Guide to Health Insurance for People with Medicare*
   c. Outline of Medicare Supplement Coverage d. Other _____
   I further certify that I have delivered the documents to the Applicant(s) *(check all that apply; must select at least one)*:
   Date _____ ☐ In person ☐ Mail ☐ Email ☐ Fax ☐ Other *(explain)* _____
4. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?
   Applicant A: ☐ YES ☐ NO **Applicant B:** ☐ YES ☐ NO
   If YES, give name of company, reason, and termination date:
   A _____
   B _____

NOTES: Please provide additional information that may assist in processing this application (*attach a separate sheet if needed*).

_____

I certify that I have interviewed the Applicant(s), asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant(s).

Printed name of licensed Agent	Signature of licensed Agent	Writing number	Percentage
Printed name of 2nd licensed Agent	Signature of 2nd licensed Agent	Writing number	Percentage

CIGNA NATIONAL HEALTH INSURANCE COMPANY
PO BOX 5700, Scranton, PA 18505-5700 • 866-459-4272

KENTUCKY MEDICARE SUPPLEMENT COMPARISON STATEMENT

Current Insurance _____ Annual Premium $_____
(Insurer Name)

Proposed Insurance _____ Annual Premium $_____
(Insurer Name)

MEDICARE (PART A): HOSPITAL INSURANCE – COVERED SERVICES PER BENEFIT PERIOD (1)				PRIVATE INSURANCE CHECKLIST	
Service	**Benefit**	**Medicare Pays***	**You Pay***	**Current Insurance Pays Plan____****	**Proposed Insurance Pays Plan ____**
HOSPITALIZATION Semiprivate room and board, general nursing, and miscellaneous hospital services and supplies	First 60 days	All but $1,632	$1,632		
	61st to 90th day	All but $408 a day	$408 a day		
	91st to 150th day***	All but $816 a day	$816 a day		
	Beyond 150 days	Nothing	All costs		
POSTHOSPITAL SKILLED NURSING FACILITY CARE In a facility approved by Medicare, you must have been in a hospital for at least 3 days and enter the facility within 30 days after hospital discharge (2)	First 20 days	100% of approved amount	Nothing		
	Additional 80 days	All but $204 a day	$204 a day		
	Beyond 100 days	Nothing	All costs		
HOME HEALTH CARE	Visits limited to medically-necessary skilled care	Full cost of services; 80% of approved amount for durable medical equipment	Nothing for services; 20% of approved amount for durable medical equipment		
HOSPICE CARE Available to terminally ill	Up to 210 days if doctor certifies need	All but limited costs for outpatient drugs and inpatient respite care	Limited cost sharing for outpatient drugs and inpatient respite care		
BLOOD	Blood	All but first 3 pints	For first 3 pints****		
FOREIGN TRAVEL	Medically-necessary emergency care in a foreign country	Emergency hospital services in qualified Mexican or Canadian hospitals*****	All costs not covered by Medicare		

* These figures are for year **2024** and are subject to change each year.

** If the policy being replaced is not a standardized policy, insert "N/A" after "Plan" and complete this column.

*** 60 reserve days may be used only once; days used are not renewable.

**** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

***** Please refer to your Medicare Handbook for more information.

(1) Benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital or skilled nursing facility for 60 days in a row.

(2) Medicare and private Medicare Supplement insurance will not pay for most nursing home care. You pay for custodial care and most care in a nursing home.

MEDICARE (PART B): HOSPITAL INSURANCE – COVERED SERVICES PER CALENDAR PERIOD				PRIVATE INSURANCE CHECKLIST	
Service	**Benefit**	**Medicare Pays**	**You Pay**	**Current Insurance Pays Plan____***	**Proposed Insurance Pays Plan ____**
MEDICAL EXPENSE Physician's services, inpatient and outpatient medical services and supplies, physical and speech therapy, ambulance, etc.	Medicare pays for medical services in or out of the hospital	80% of approved amount (after $240 deductible)	$240 deductible** plus 20% of balance of approved amount (plus up to 15% above approved charge)***		
HOME HEALTH CARE	Visits limited to medically-necessary skilled care	Full cost of services; 80% of approved amount for durable medical equipment (after $240 deductible)	Nothing for services; 20% of approved amount for durable medical equipment (after $240 deductible)		
AT-HOME RECOVERY BENEFIT	Short-term at-home assistance with activities of daily living****	Nothing	All costs		
OUTPATIENT HOSPITAL TREATMENT	Unlimited if medically necessary	80% of approved amount (after $240 deductible)	Subject to deductible plus 20% of approved amount		
BLOOD	Blood	80% of approved amount (after $240 deductible and starting with 4th pint)	First 3 pints plus 20% of approved amount (after $240 deductible)*****		
PREVENTIVE CARE – PATIENT EDUCATION	Annual physical exam, preventive testing, influenza vaccines	Screening pap smears once every 24 months; screening mammograms every 12 months	All cost not covered by Medicare		
OUTPATIENT PRESCRIPTION DRUGS	Outpatient prescription drugs	Nothing	All costs		
FOREIGN TRAVEL	Medically-necessary emergency care in a foreign country	Doctor and ambulance service in Canada and Mexico if in connection with covered inpatient	All costs not covered by Medicare		
OTHER******					

* If the policy being replaced is not a standardized policy, insert "N/A".

** Once you have had $240 of expense for covered services in year **2024**, the Part B deductible does not apply to any further covered services you receive for the rest of the year.

*** YOU PAY FOR charges higher than the amount approved by Medicare unless the doctor or supplier agrees to accept Medicare's approved amount as the total charge for services rendered.

**** At-home recovery benefits must be received in conjunction with Medicare-approved home health care benefits.

***** To the extent the blood deductible is met under one part of Medicare during the calendar year, it does not have to be met under the other part.

****** Use this area to compare pre-standardization and/or innovative benefits.

TO APPLICANT: Do not sign this form unless it has been explained to you.

Applicant	Date	Agent	Date

NOTICE TO AGENT/INSURER: This form is to be retained by the replacing insurer and attached to the replacement policy.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA NATIONAL HEALTH INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

☐ **Joint Account** – ***only one form is needed for Joint Account*** ☐ **Applicant A only** ☐ **Applicant B only**		
Proposed Insured Name		**Policy Number** *(if available)*
Financial Institution Name and Telephone Number		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date** *(1st - 28th)*

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

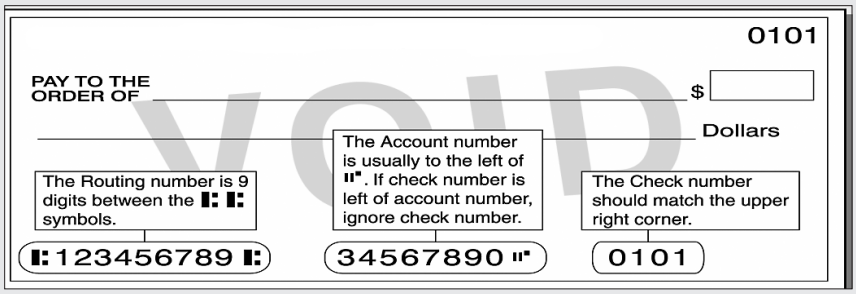
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Cigna National Health Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Cigna National Health Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Cigna National Health Insurance Company mistakenly deposits funds into my account, I authorize Cigna National Health Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR CIGNA NATIONAL HEALTH INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Cigna National Health Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Cigna National Health Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Cigna National Health Insurance Company upon 30 days written notice.

Name of Payor *(if other than Insured)* **Payor's Address**

Print name of Depositor *(as it appears on account)* **Signature of Depositor** **Date**

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA NATIONAL HEALTH INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

☐ **Joint Account** – ***only one form is needed for Joint Account*** ☐ **Applicant A only** ☐ **Applicant B only**		
Proposed Insured Name		**Policy Number** *(if available)*
Financial Institution Name and Telephone Number		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date** *(1st - 28th)*

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

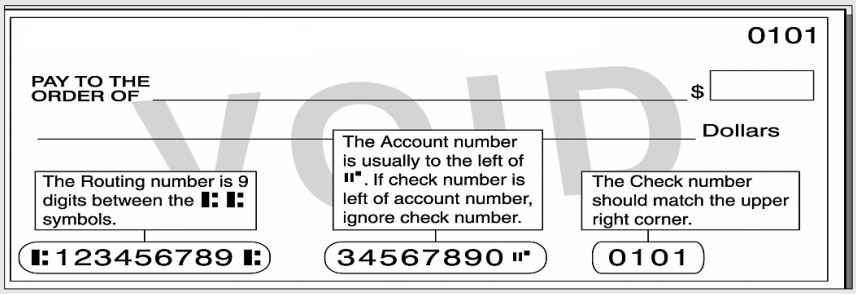
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Cigna National Health Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Cigna National Health Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Cigna National Health Insurance Company mistakenly deposits funds into my account, I authorize Cigna National Health Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR CIGNA NATIONAL HEALTH INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Cigna National Health Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Cigna National Health Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Cigna National Health Insurance Company upon 30 days written notice.

Name of Payor *(if other than Insured)* **Payor's Address**

Print name of Depositor *(as it appears on account)* **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB Group, LLC, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB Group, LLC, information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB Group, LLC.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant A Name

Name of Applicant A Personal Representative, if applicable

Applicant A Social Security Number

Relationship of Personal Representative to Applicant A

Applicant A Signature **Date**

Signature of Personal Representative **Date**

Applicant B Name

Name of Applicant B Personal Representative, if applicable

Applicant B Social Security Number

Relationship of Personal Representative to Applicant B

Applicant B Signature **Date**

Signature of Personal Representative **Date**

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

Applicant A Name

Applicant A Signature **Date**

Name of Applicant A Personal Representative, if applicable

Relationship of Personal Representative to Applicant A

Signature of Personal Representative **Date**

Applicant B Name

Applicant B Signature **Date**

Name of Applicant B Personal Representative, if applicable

Relationship of Personal Representative to Applicant B

Signature of Company's Agent **Date**

Signature of Personal Representative **Date**

A signed copy of this form will be provided to you.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna National Health Insurance Company (CNHIC) with the application.

A copy of this form must also be left with the Applicant.

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

CIGNA NATIONAL HEALTH INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

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 a policy to be issued by Cigna National Health 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, OR BROKER

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 coverage is being purchased for the following reason (check one):

Applicant A

- ☐ 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) _____

_____

Applicant B

- ☐ 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 premiums 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.

_____ _____
Agent/Broker printed name and signature **Date**

_____ _____
Applicant A signature **Date**

_____ _____
Applicant B signature **Date**

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna National Health Insurance Company (CNHIC) with the application.

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- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

Applicant B

- ☐ 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 premiums 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.

_____ _____
Agent/Broker printed name and signature **Date**

_____ _____
Applicant A signature **Date**

_____ _____
Applicant B signature **Date**

DISCRIMINATION IS AGAINST THE LAW

Medicare Supplement coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card or call 1.866.459.4272 (TTY: Dial 711), and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call 1.866.459.4272 (TTY: Dial 711), or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.868.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.866.459.4272 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.866.459.4272 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.866.459.4272（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.866.459.4272 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.866.459.4272 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.866.459.4272 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.866.459.4272 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.866.459.4272 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.866.459.4272 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.866.459.4272 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.866.459.4272 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1.866.459.4272 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.866.459.4272（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.866.459.4272 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.866.459.4272 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.866.459.4272 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).