

CONSECO INSURANCE COMPANY
A life and health insurance company



Medicare **supplement**

Conseco Insurance Company
Medicare supplement
CIC-1000

Application book • Missouri
(Accompanies Outline of Coverage)

Medicare supplement application submission checklist:

- Application
- Collect premium amount
- Provide client with Buyer's Guide
- Provide client with Outline of Coverage
- Provide client with official receipt
- Complete HIPAA authorization form, leave one copy with the applicant and mail one copy the application
- Complete Replacement Notice and leave copy with the applicant if necessary

Conseco Insurance Company

Administrative Office: 11815 North Pennsylvania Street • Carmel, Indiana 46032



Application for Medicare Supplement Policy

<input type="checkbox"/> New Coverage	<input type="checkbox"/> Change in Coverage	<input type="checkbox"/> Reinstatement
If Change in coverage or reinstatement please provide policy number: _____		
Date of first enrollment in Medicare Part B _____		
Select One: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan D <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G	Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly PAC	Application Fee (nonrefundable): \$ _____ Total Premium Collected: \$ _____

Please Print

First Name, Middle Initial & Last Name of Person to be Insured				Date of Birth (Mo/Day/Yr)		Age	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Effective Date:	List Best Time of Day to Contact you:	Height (Feet & Inches)		Weight (Pounds)				
HOME ADDRESS Street City State Zip Code County				Home Phone ()					
				Work Phone ()					
E-mail address:									
BILLING ADDRESS (If different from Home Address): Street/P.O Box				City		State		Zip Code	

SECTION 1 – GENERAL QUESTIONS

1. Are you insured under Part A and Part B of Medicare?	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Is the state paying your Medicare Part B program?	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Are you enrolled in a Health Maintenance Organization or a similar program?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Do you receive federal, state or local government financial assistance in any form, such as Supplemental Social Security?	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you used tobacco in any form, in the last 24 months?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Are you applying during open enrollment?	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Are you applying during a guaranteed issue period?.....	Yes <input type="checkbox"/> No <input type="checkbox"/>
If applying outside Open Enrollment or Guarantee Issue periods, please use application AP-1000UW	

SECTION 2 – GUARANTEED ISSUE

This will determine if you are eligible for guaranteed issue other than the open enrollment period that is offered when you first qualified for Medicare Part B. In order to determine eligibility for this additional 63 day guaranteed issue period, you must provide certain information and documentation of termination or disenrollment in certain Medicare or Medicare Supplement coverage. The company terminating your plan is required to notify you, in writing, of the termination of the plan and the reason for termination.	
EMPLOYEE WELFARE BENEFIT PLAN A. Within the past 63 days, did the plan terminate ALL of your Medicare supplemental benefits? <i>If "Yes", you are eligible for guarantee issue.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
MEDICARE + CHOICE PLAN B. Within the past 12 months and upon first becoming eligible for benefits under Medicare Part A at age 65, did you enroll in a Medicare + Choice Plan and disenroll from the plan within the past 63 days? <i>If "Yes", you are eligible for guarantee issue.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>
MEDICARE SELECT PLAN, MEDICARE RISK OR COST PLAN OR A MEDICARE HMO PLAN C. Within the past 12 months, did you terminate Medicare supplement coverage to enroll in a Medicare Select Plan, Medicare Risk or Cost Plan or a Medicare HMO Plan? If "Yes", complete the following information: Company Name: _____ Policy/Certificate Number: _____	Yes <input type="checkbox"/> No <input type="checkbox"/>

<p>D. Within the past 63 days, did you terminate the Medicare Select Plan, Medicare Risk or Cost Plan or the Medicare HMO Plan?</p> <p>If you answer "Yes" to C. and D., you are eligible for guarantee issue. However, you must contact your prior Medicare Supplement insurer to re-enroll in the same plan. If the plan is not available with your prior Medicare Supplement insurer, then you are eligible for Plans A, B, C or F.</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>E. Within the past 63 days, did your Medicare Select Plan, Medicare Risk or Cost Plan or your Medicare HMO Plan:</p> <p>a. terminate because its certification terminated?.....</p> <p>b. terminate or otherwise discontinue in the area in which you live?</p> <p>c. terminate because you changed your place of residence which caused you to no longer be eligible for the plan?</p> <p>d. terminate because the provider substantially violated a material provision of the plan such as the failure to provide on a timely basis medically necessary care for which benefits are available or failure to provide such covered care in accordance with applicable quality standards?.....</p> <p>e. terminate because the plan, agent or other entity acting on the plan's behalf materially misrepresented the plan's provision in marketing the plan to you?</p> <p>f. terminate because of other exception conditions for the termination of the plan?.....</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>MEDICARE SUPPLEMENT POLICY</p>	
<p>F. Within the past 63 days, did your Medicare Supplement policy:</p> <p>a. enrollment terminate because of the insolvency or bankruptcy of the insuring company?.....</p> <p>b. terminate because the company issuing the Medicare supplement policy substantially violated a material provision of the policy?</p> <p>c. terminate because the company, agent or other entity acting on the organization's behalf materially misrepresented the Medicare Supplement policy's provision in marketing the plan to you?.....</p> <p><i>(NOTE: An increase in premium does not constitute a violation of a material provision of the policy or a material misrepresentation of the policy.)</i></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>OTHER GUARANTEE ISSUE CIRCUMSTANCES:</p>	

SECTION 3 – OTHER HEALTH COVERAGE

<p>To the best of your knowledge:</p>	
<p>1. Do you have another Medicare Supplement policy or certificate in force?</p> <p>If "Yes",</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a) list company and policy number for each such policy or certificate:</p> <p>b) Do you intend to replace this Medicare Supplement coverage with this policy?</p> <p>If answered yes, you need to complete the form entitled "Notice to Applicant Regarding Replacement".</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>2. Do you have any other health insurance policies that provide benefits similar to this Medicare Supplement policy?</p> <p>If "Yes",</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a) list company and policy number for each such policy or certificate:</p> <p>b) describe the kind of coverage provided:</p> <p>c) do you intend to replace this with the policy being applied for?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If no, why is this additional coverage needed?</p>	
<p>3. Are you covered for medical assistance through the state Medicaid program:</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>a) as a Specified Low-Income Medicare Beneficiary (SLMB)?</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>b) as a Qualified Medicare Beneficiary (QMB)?.....</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>c) for other Medicaid medical benefits?.....</p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

STATEMENTS TO PROPOSED INSURED

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- The benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for up to 24 months. You must request suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

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).

ACKNOWLEDGMENT

I acknowledge receipt of an Outline of Coverage, Buyer's Guide and Disclosure Statement, which includes the Medical Information Bureau Notice, the Notice of Insurance Information Practices and the Fair Credit Reporting Act Notice.

AGREEMENT

I hereby apply to CONSECO INSURANCE COMPANY ("the Company") for a policy to be issued in reliance on my written answers to the questions on this application, and have tendered the premium indicated for the coverage applied for to the Company. It is understood and agreed that submission of this application and of the amount stated does not place any insurance in force. In the event an application is submitted without a payment or if the amount paid is not honored by the bank, the Company has no liability until a policy is approved, delivered, and has accepted the full first modal premium payment.

I hereby agree that (1) all statements and answers are, to the best of my knowledge and belief, full, complete and true, and I understand that if any answers are not complete and true, the policy may not be valid; and (2) the policy shall not be effective unless it is approved, delivered, and the full first modal premium paid while all proposed insureds are alive and in good health and other conditions remain as described in this form. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application/enrollment form or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SIGNATURES

Date Signed at City _____ State _____ Zip _____
this _____ Day of _____ 20 _____
Signature of Applicant X _____
Social Security Number: _____
Medicare Number: _____

AGENT'S STATEMENT

1. Did you interview each proposed insured in person, ask all questions and witness the signature?..... Yes No

If "No", please explain the circumstances under which the application was completed.

2. List any other medical or health insurance policies that you have sold to the proposed insured:

(a) From the above list, please indicate which policies are still in force. _____

(b) List policies that you have sold to the insured in the past five (5) years which are no longer in force, if any: _____

I certify that the proposed insured's answers to the questions were fully and accurately recorded in the application; that the questions in the Agent's Statement have been answered accurately; and that the Outline of Coverage and the Buyer's Guide have been given to the proposed insured(s).

Signature of Licensed Resident Agent X _____

Printed Name of Agent _____

Agent Number _____ Agent Phone # _____

(Agent's Signature Not Needed When Dealing Directly With Home Office)

Mail to Agent Mail to Applicant

MAKE ALL CHECKS PAYABLE ONLY TO CONSECO INSURANCE COMPANY

Conseco Insurance Company

Administrative Office: 11815 North Pennsylvania Street • Carmel, Indiana 46032

Application for Medicare Supplement Policy



CONSECO

<input type="checkbox"/> New Coverage	<input type="checkbox"/> Change in Coverage	<input type="checkbox"/> Reinstatement
If change in coverage or reinstatement please provide policy number: _____		
1. Are you applying during open enrollment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
2. Are you applying in a guarantee issue period?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
3. Date of first enrollment in Medicare Part B _____		
If applying during Open Enrollment or Guarantee Issue periods, please use application AP-1000OE		
Select One: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan D <input type="checkbox"/> Plan F <input type="checkbox"/> Plan G	Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly PAC	Application Fee (nonrefundable): \$ _____ Total Premium Collected: \$ _____
		Rate Class: <input type="checkbox"/> Preferred <input type="checkbox"/> Standard

Please Print

First Name, Middle Initial & Last Name of Person to be Insured			Date of Birth (Mo/Day/Yr)		Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married	Effective Date:	List Best Time of Day to Contact you:	Height (Feet & Inches)		Weight (Pounds)	
HOME ADDRESS Street	City	State	Zip Code	County	Home Phone ()	
					Work Phone ()	
E-mail address:						
BILLING ADDRESS (If different from Home Address): Street/P.O Box						
		City	State	Zip Code	County	

SECTION 1 – GENERAL QUESTIONS

1. Are you insured under Part A and Part B of Medicare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the state paying your Medicare Part B program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you enrolled in a Health Maintenance Organization or a similar program?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you receive federal, state or local government financial assistance in any form, such as Supplemental Social Security?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 2 – OTHER HEALTH COVERAGE

To the best of your knowledge:	
1. Do you have another Medicare Supplement policy or certificate in force?..... If "Yes",	<input type="checkbox"/> Yes <input type="checkbox"/> No
a) list company and policy number for each such policy or certificate: _____	
b) Do you intend to replace this Medicare Supplement coverage with this policy?..... If answered yes, you need to complete the form entitled "Notice to Applicant Regarding Replacement".	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have any other health insurance policies that provide benefits similar to this Medicare Supplement policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes",	
a) list company and policy number for each such policy or certificate: _____	
b) describe the kind of coverage provided: _____	
c) do you intend to replace this with the policy being applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, why is this additional coverage needed? _____	
3. Are you covered for medical assistance through the state Medicaid program:	
a) as a Specified Low-Income Medicare Beneficiary (SLMB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) as a Qualified Medicare Beneficiary (QMB)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) for other Medicaid medical benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 3 – GENERAL HEALTH QUESTIONS

IF YOU ARE APPLYING DURING OPEN ENROLLMENT PERIOD OR IF YOU ARE ELIGIBLE FOR GUARANTEED ISSUE COVERAGE, PLEASE USE APPLICATION AP-1000OE DO NOT COMPLETE THIS APPLICATION

If the answer to any question in Section 3 is “yes”, the proposed insured is not eligible for coverage.	
1. Are you now confined, or have you been advised by a doctor to seek medical care or treatment either in a hospital or in a nursing home in the past 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you received Medicare approved home health care within the past 60 days?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. In the past 24 months, have you been hospitalized two or more times?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. In the past 24 months, have you been told you will need surgery but it has not yet been done?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 24 months have you had, or been advised to have kidney dialysis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Within the past 24 months have you had any type of heart surgery, including angioplasty, bypass, valvular replacement or stent placement?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Are you receiving or have you received, within the past 24 months, medical advice or treatment for:	
a. Stroke or Transient Ischemic Attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Angina Pectoris, Heart Attack, Congestive Heart Failure, Valvular Heart Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Cardiomyopathy or Heart Rhythm Disorder requiring a defibrillator?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Chronic Lung Disease, use of a mechanical breathing device or oxygen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Liver diseases, including cirrhosis, hepatitis or cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Amputation or organ transplant due to disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Disabling arthritis, disabling degenerative disk disease, degenerative bone disease, or Osteoporosis with compression fracture history?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Diabetic requiring insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Systemic Lupus?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Parkinson’s Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Alzheimer’s Disease, Senile Dementia, Organic Brain Disorder, or other Senility Disorders?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Mental/nervous disorder requiring psychiatric care?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Been treated for or advised to seek treatment for drug or alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Cancer (except skin), malignant Melanoma, Leukemia or Hodgkin’s Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you bedridden or do you require the use of a wheelchair?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you tested positive for Human Immune Virus (HIV) or do you have Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/> Yes <input type="checkbox"/> No

SECTION 4 – ADDITIONAL INFORMATION

1. Have you used tobacco in any form, in the last 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Are you a diabetic controlled by diet or oral medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you taken any prescription medications within the last 12 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If “yes”, please provide details: Doctors Name, Current Medication, Length Taken, Dosage, Frequency, and Reason for taking.	

STATEMENTS TO PROPOSED INSURED

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- The benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for up to 24 months. You must request suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.

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).

ACKNOWLEDGMENT

I acknowledge receipt of an Outline of Coverage, Buyer's Guide and Disclosure Statement, which includes the Medical Information Bureau Notice, the Notice of Insurance Information Practices and the Fair Credit Reporting Act Notice.

AGREEMENT

I hereby apply to CONSECO INSURANCE COMPANY ("the Company") for a policy to be issued in reliance on my written answers to the questions on this application, and have tendered the premium indicated for the coverage applied for to the Company. It is understood and agreed that submission of this application and of the amount stated does not place any insurance in force. Should it be determined that coverage is to be declined based on the Company's underwriting rules, the amount submitted will be returned. In the event an application is submitted without a payment or if the amount paid is not honored by the bank, the Company has no liability until a policy is approved, delivered, and has accepted the full first modal premium payment.

I hereby agree that (1) all statements and answers are, to the best of my knowledge and belief, full, complete and true, and I understand that if any answers are not complete and true, the policy may not be valid; and (2) the policy shall not be effective unless it is approved, delivered, and the full first modal premium paid while all proposed insureds are alive and in good health and other conditions remain as described in this form. I also understand that the agent cannot determine eligibility for or alter the terms of the proposed policy.

WARNING: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application/enrollment form or files a claim containing a false or deceptive statement is guilty of insurance fraud.

SIGNATURES

Date Signed at City _____ State _____ Zip _____

this _____ Day of _____ 20 _____

Signature of Applicant X _____

Social Security Number: _____

Medicare Number : _____

AGENT'S STATEMENT

1. Did you interview each proposed insured in person, ask all questions and witness the signature?.....
If "No", please explain the circumstances under which the application was completed.

Yes No

2. List any other medical or health insurance policies that you have sold to the proposed insured:

(a) From the above list, please indicate which policies are still in force. _____

(b) List policies that you have sold to the insured in the past five (5) years which are no longer in force, if any: _____

I certify that the proposed insured's answers to the questions were fully and accurately recorded in the application; that the questions in the Agent's Statement have been answered accurately; and that the Outline of Coverage and the Buyer's Guide have been given to the proposed insured(s).

Signature of Licensed Resident Agent X _____

Printed Name of Agent _____

Agent Number _____ Agent Phone # _____

(Agent's Signature Not Needed When Dealing Directly With Home Office)

Mail to Agent

Mail to Applicant

MAKE ALL CHECKS PAYABLE ONLY TO CONSECO INSURANCE COMPANY

CONSECO INSURANCE COMPANY

**AUTHORIZATION FOR UNDERWRITING PURPOSES
Pursuant to the HIPAA Privacy Rule §164.508(c)**

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer or Government agency to disclose personal information about me as described below.

This authorization was prepared by Conseco Insurance Company for purposes of obtaining personal information necessary to underwrite the application for insurance submitted with this authorization. The information subject to this authorization is any and all health information being requested by Conseco Insurance Company for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by this authorization does not include psychotherapy notes but does include information about drug abuse, alcoholism, and mental illness. In addition, the information covered by this authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by Conseco Insurance Company to perform tasks related to the underwriting process are hereby authorized to use the personal information covered by this authorization. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information will likely no longer be protected by the federal privacy regulations and may be subject to redisclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Conseco Insurance Company, or, so long as Conseco Insurance Company has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

ATTN: Privacy Office
Conseco Insurance Company
PO Box 1916
Carmel, Indiana 46082-1916

I understand that my application for insurance can be declined if I choose not to sign this authorization. This authorization is valid for a period of twenty-four months from the date of my signature. A copy of this authorization may be used in place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is Covered By This Authorization

Signature of Individual and Date

(Please Print) Name of Representative with authority to act on behalf of the Individual Whose Information Is Covered By This Authorization

Relationship of Representative to Individual

Signature of Representative and Date

APPLICANT COPY

CONSECO INSURANCE COMPANY

**AUTHORIZATION FOR UNDERWRITING PURPOSES
Pursuant to the HIPAA Privacy Rule §164.508(c)**

I, the undersigned, authorize any licensed physician, medical practitioner, hospital, clinic, medical or medical related facility, the Veteran's Administration, insurance company, the Medical Information Bureau, Inc. (MIB), employer or Government agency to disclose personal information about me as described below.

This authorization was prepared by Conseco Insurance Company for purposes of obtaining personal information necessary to underwrite the application for insurance submitted with this authorization. The information subject to this authorization is any and all health information being requested by Conseco Insurance Company for the purpose stated above as well as any information provided to them or their affiliated insurance companies on any previous applications. The information covered by this authorization does not include psychotherapy notes but does include information about drug abuse, alcoholism, and mental illness. In addition, the information covered by this authorization does include any such information that has been restricted by my request.

Persons or entities employed by or authorized by Conseco Insurance Company to perform tasks related to the underwriting process are hereby authorized to use the personal information covered by this authorization. I understand that if the person or entity that receives this information is not a health care provider or health plan covered by federal privacy regulations, the information will likely no longer be protected by the federal privacy regulations and may be subject to redisclosure. However, I further understand that all such persons or entities have signed agreements to protect said information.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Conseco Insurance Company, or, so long as Conseco Insurance Company has a legal right to contest the coverage or a claim under the coverage. Revocation requests must be sent in writing to:

ATTN: Privacy Office
Conseco Insurance Company
PO Box 1916
Carmel, Indiana 46082-1916

I understand that my application for insurance can be declined if I choose not to sign this authorization. This authorization is valid for a period of twenty-four months from the date of my signature. A copy of this authorization may be used in place of the original. If this authorization is for someone other than myself, that individual and my authority to act on his/her behalf are explained below.

(Please Print) Name of Individual Whose Information is Covered By This Authorization

Signature of Individual and Date

(Please Print) Name of Representative with authority to act on behalf of the Individual Whose Information Is Covered By This Authorization

Relationship of Representative to Individual

Signature of Representative and Date

ADMINISTRATIVE OFFICE COPY

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

CONSECO INSURANCE COMPANY
Administrative Office: 11815 N. Pennsylvania Street • Carmel, IN 46032

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

According to () your application, () information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Conseco 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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical and health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- Fewer benefits and lower premiums.
- No change in benefits, but lower premiums.
- Other. (please specify) _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. **Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

Signature of Agent X _____

Conseco Insurance Company,
11815 N. Pennsylvania Street • Carmel, IN 46032

Applicant's Signature X _____

Date _____

CIC-REPLACENOTICE

APPLICANT'S COPY

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

CONSECO INSURANCE COMPANY
Administrative Office: 11815 N. Pennsylvania Street • Carmel, IN 46032

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

According to () your application, () information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Conseco 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 coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY AGENT: I have reviewed your current medical and health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- Fewer benefits and lower premiums.
- No change in benefits, but lower premiums.
- Other. (please specify) _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. **Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

Signature of Agent X _____

Conseco Insurance Company,
11815 N. Pennsylvania Street • Carmel, IN 46032

Applicant's Signature X _____

Date _____

CIC-REPLACENOTICE

ADMINISTRATIVE OFFICE COPY

DISCLOSURE STATEMENT ALWAYS LEAVE WITH APPLICANT(S)

MEDICAL INFORMATION BUREAU NOTICE - Information regarding your insurability will be treated as confidential. We or our reinsurers may, however, make a brief report thereon to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members for the purpose of protecting its members and their policyholders from bearing the expense created by those who would conceal facts relevant to their insurability. If you apply to another bureau member for life or health insurance, or if a claim is made to such a company, the bureau, upon request, will furnish that company with information about you from its files. We or our reinsurers may release information in our files to other life insurance companies to whom you might apply for life or health insurance, or to whom a claim for benefits may be submitted.

Upon your request, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of any information in the Bureau's files, you may seek correction from the Bureau as provided by the Fair Credit Reporting Act. The address of the Bureau's information office is: 160 University Avenue, Westwood, Massachusetts 02090. The telephone number is (617) 426-3660.

NOTICE OF INSURANCE INFORMATION PRACTICES - To evaluate your application, we will need some personal information about you. It may be necessary to obtain some information from sources other than yourself. For your protection, you have a qualified right to learn what information we obtain about you. You also have the right to request correction of any erroneous information, although the information we obtain about you is confidential. In some cases we may disclose information to others without your specific authorization. We will furnish a more detailed summary of our information practices upon request.

FAIR CREDIT REPORTING ACT NOTICE - As part of our evaluation of your application for insurance, an investigative consumer report may be prepared whereby information is obtained through personal interviews with agencies, friends, neighbors or others with whom you are acquainted or who may have information about you. This report among other things may include information as to your character, general reputation, personal characteristics, health and mode of living. Upon your written request and within a reasonable period of time, you have the right to receive additional detailed information about the nature and scope of the investigation and to receive a copy of the report at your expense.

MIB-MS (1/01)

CASH RECEIPT

Received of _____ this _____ day of _____ the sum of \$ _____ being the payment of premium. The insurance applied for will not take effect until the effective date of the applicant's policy and the payment of the first premium, whichever is later, provided the applicant remains in good health. If the insurance is applied for during the applicant's Medicare Open Enrollment period, no evidence of good health will be required.

CIC-RECEIPT

Conseco insurance companies Request to draft premium by Electronic Funds Transfer (EFT)

Please check the appropriate options.

Be sure to include a VOIDED CHECK or this request cannot be processed!

1. Administrative office will process the draft for the initial premium within 48 hours of receiving the application
2. Include a copy of a voided check with initial premium by EFT in the special remarks section of the application.
3. Complete the authorization below.
4. **Fax completed form with application and copy of a voided check to (317) 817-2322, Attn: New Business department**

 Authorization to draft initial premium

Upon the receipt of this form please process a draft for the initial premium, in the amount of \$_____, for the application shown below. I am aware that the draft will be processed within 48 hours of receipt of this request in the administrative office.

YES! PLEASE DEDUCT FUTURE PREMIUMS

By selecting this option you are authorizing subsequent renewal premiums to be deducted from the bank account listed above. These premiums will be deducted on a monthly basis on the _____ day of the month.

**AUTHORIZATION TO HONOR DEDUCTIONS DRAWN BY CONSECO HEALTH INSURANCE COMPANY OR
CONSECO INSURANCE COMPANY**

I hereby request and authorize you to honor and charge to my account deductions drawn on my account by and payable to Conseco Health Insurance Company or Conseco Insurance Company. The signatures on such deductions may be either typed or printed. If any such deductions are dishonored, either with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance. This authorization shall continue in force until revoked by me in writing and received by you, a copy of which revocation shall be sent by me to the Company, at its administrative offices in Carmel, Indiana. The Company is instructed to forward authorization to you.

Applicant name _____

Date of birth or SSN _____

Account holder name (if different) _____

Financial institution/bank name _____

Routing no. _____ Bank account no. _____

Account holder signature _____ Date _____

The acceptance of this form and the initial premium payment is not a guarantee that the application for insurance will be approved and a policy issued.

Conseco Health Insurance Company and Conseco Insurance Company are members of the Conseco insurance companies.

Medicare supplement
from Conseco Insurance Company
is part of the Conseco Solutions®
family of products.

Policy form: CIC-1000

CONSECO INSURANCE COMPANY
Administrative Office
11815 N. Pennsylvania Street
Carmel, IN 46032

AB-1000-MO (01/05) 123336
© 2005 Conseco Services, L.L.C.

conseco.com



CONSECO®
Step up.