2019 Advantage to Supplement Annual Review Form

Thank you for taking the time to fill out our form. This form is for individuals who currently have an Advantage Plan and would like to switch to traditional Medicare with a Supplement and Prescription Plan. If this is not your situation you have the wrong form and need to go back to the selections.

General Information

Fill out this section completely.

Full Name: _____

Nick Name (if any): _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

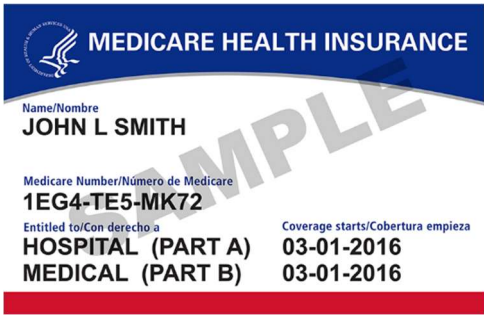
Home Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____

Current Advantage Plan: _____

Medicare Card Update



Medicare Number:

_____

Hospital (Part A) effective date: _____

Medical (Part B) effective date: _____

Select One:

____I take 3 or less prescriptions so I do not need to have a mymedicare.gov account created.
____I have created a mymedicare.gov account and by providing my login information give you permission to access my information to quote my coverage.
My login is:_____ My password is: _____
____I give you permission to create a mymedicare.gov account on my behalf. I understand that I will be provided my login and password created for me.

Sign: _____ Date: _____

Continue on the next page

Medicare Supplement Underwriting Questionaire

	YES	NO
1. Are you currently 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 currently 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 currently have a terminal illness or are you currently 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 currently receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; or have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐
5. Do you have now or at any time have you been treated for or advised by a medical professional to have treatment for amputation caused by disease or organ transplant other than corneas?	☐	☐
6. Within the past five (5) years, 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.)	☐	☐
7. Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately- licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	☐	☐
8. Do you have now or in the last two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for the following conditions:		
a. internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma? .	☐	☐
b. angina, atherosclerosis, arteriosclerosis, peripheral vascular disease, heart attack, irregular heartbeat, atrial fibrillation, cardiomyopathy, congestive heart failure, angioplasty, stent placement, carotid artery disease, coronary artery disease (CAD), heart valve surgery, coronary bypass, cardiac pacemaker, implantable or subcutaneous defibrillator? (You should answer NO if your only treatment is with maintenance medication.)	☐	☐
c. Parkinson's disease, myasthenia gravis, cerebral palsy, muscular dystrophy, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease)?	☐	☐
d. Paget's disease, rheumatoid arthritis, disabling arthritis, systemic lupus, osteoporosis with fractures, or paralysis?	☐	☐
e. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?	☐	☐
f. diabetes with hypertension requiring three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	☐	☐
g. diabetes with: neuropathy, retinopathy, vascular disease, or tobacco use?	☐	☐

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(8. Continued) Do you have now or in the last two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for the following conditions:

	YES	NO
h. chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or any other chronic lung or respiratory disorder requiring the use of oxygen?	☐	☐
i. major depression, bipolar disorder, schizophrenia, or a paranoid disorder?	☐	☐
j. dementia, senility, Alzheimer's disease, or organic brain disorder?	☐	☐
k. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder?	☐	☐
l. hepatitis (other than hepatitis A), alcohol or drug abuse, cirrhosis of the liver, or other liver disease?	☐	☐
m. stroke or transient ischemic attack (TIA)?	☐	☐

If you answered "yes" to any of the above questions we will be unable to switch you to a supplement. Please return to the main page and fill out the Advantage Plan Form.

If all of your above answers are "no" please continue on the next page.

Prescription Plan Information for Quoting

Choose One:

I prefer picking up my prescriptions at a pharmacy. I prefer using a mail order service I do not have a preference

What, if any, is/are your preferred pharmacy(s):_____

Prescriptions

If you created a myMedicare.gov account and filled in your own prescriptions you do not need to fill out the prescription portion of this form. All others please continue.

Important Note: If you take a prescription "as needed" please provide the approximate number of times you fill your prescription each year. We need to know your best estimate on how often you will refill your prescription throughout a calendar year. Double check spelling and dosage on your prescriptions. In addition, please write down the generic name instead of the brand name if that is what you take. Be sure to write down the entire prescription. If there is an ER or other abbreviation after the name that will affect the quote. Incorrect or incomplete information greatly slows down our quoting process and can lead to inaccurate quotes. Thank you in advance for being thorough.

Name (Example: Simvastatin)	Dosage (Example: 40mg tablet)	Frequency (Example: 1x daily)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

(Continue on the next page if needed)

Name (Example: Simvastatin)	Dosage (Example: 40mg tablet)	Frequency (Example: 1x daily)
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		
21.		
22.		
23.		

Submitting Your Form:

The Scope of Appointment Form (on the following page) Must be completed and submitted with this form.

To submit you can:

-Scan and Email it to: review@KeysToMedicare.com
-Fax it to: 317-558-9889
-Mail it to: Keys To Medicare
15010 Glenmoor Cir.
Carmel, IN 46033

All Forms Must Be Received Before Thanksgiving to Ensure Your Review Will Be Completed by the December 7th Deadline.

Scope of Appointment Confirmation Form

Before meeting with a Medicare beneficiary (or their authorized representative), Medicare requires that Licensed Sales Representatives use this form to ensure your appointment focuses only on the type of plan and products you are interested in. A separate form should be used for each Medicare beneficiary. **Please check what you want to discuss with the Licensed Sales Representative.**

Please indicate the product(s) you agree to discuss by checking the applicable checkbox(es):

- ☐ **Medicare Advantage Plans (Part C) and Cost Plans**
- ☐ **Stand-alone Medicare Prescription Drug Plan (Part D)**
- ☐ **Medicare Supplement (Medigap) Plan**
- ☐ **Dental-Vision-Hearing Products**
- ☐ **Hospital Indemnity Products**

By signing this form, you agree to meet with a Licensed Sales Representative to discuss the products checked above. The Licensed Sales Representative is either employed or contracted by a Medicare plan and may be paid based on your enrollment in a plan. They **do not** work directly for the federal government.

Signing this form **does not** affect your current or future enrollment in a Medicare plan, enroll you in a Medicare plan or obligate you to enroll in a Medicare plan. All information provided on this form is confidential.

Beneficiary or Authorized Representative Signature and Signature Date:

_____ _____

Signature: **Signature Date:**

If you are the authorized representative, please sign above and print clearly and legibly below:

_____ _____

Authorized Representative's Name: Your Relationship to the Beneficiary:

To be completed by the Licensed Sales Representative (print clearly and legibly):

Licensed Sales Representative Name (First_Last)	Licensed Sales Representative Phone	Licensed Sales Representative ID
Beneficiary Name (First_Last)	Beneficiary Phone (Optional)	Date Appointment will be Completed
Beneficiary Address (Optional)		
Initial Method of Contact	Plan(s) the Licensed Sales Representative will represent during the meeting	
Licensed Sales Representative Signature		

Scope of Appointment documentation is subject to CMS record retention requirements

Product Descriptions

Stand-alone Medicare Prescription Drug Plans (Part D)

Medicare Prescription Drug Plan (PDP) — A stand-alone drug plan that adds prescription drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-For-Service Plans, and Medicare Medical Savings Account Plans.

Medicare Advantage Plans (Part C) and Cost Plans

Medicare Health Maintenance Organization (HMO) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. In most HMOs, you can only get your care from doctors or hospitals in the plan's network (except in emergencies).

Medicare HMO Point-of-Service (HMO-POS) — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. HMO-POS plans may allow you to get some services out of network for a higher copayment or coinsurance.

Medicare Preferred Provider Organization (PPO) Plan — A Medicare Advantage Plan that provides all Original Medicare Part A and Part B health coverage and sometimes covers Part D prescription drug coverage. PPOs have network doctors, providers and hospitals but you can also use out-of-network providers, usually at a higher cost.

Medicare Private Fee-For-Service (PFFS) Plan — A Medicare Advantage Plan in which you may go to any Medicare-approved doctor, hospital and provider that accepts the plan's payment, terms and conditions and agrees to treat you — not all providers will. If you join a PFFS Plan that has a network, you can see any of the network providers who have agreed to always treat plan members. You will usually pay more to see out-of-network providers.

Medicare Special Needs Plan (SNP) — A Medicare Advantage Plan that has a benefit package designed for people with special health care needs. Examples of the specific groups served include people who have both Medicare and Medicaid, people who reside in nursing homes, and people who have certain chronic medical conditions.

Medicare Medical Savings Account (MSA) Plan — MSA Plans combine a high deductible health plan with a bank account. The plan deposits money from Medicare into the account. You can use it to pay your medical expenses until your deductible is met.

Medicare Cost Plan — In a Medicare Cost Plan, you can go to providers both in and out of network. If you get services outside of the plan's network, your Medicare-covered services will be paid for under Original Medicare but you will be responsible for Medicare coinsurance and deductibles.

Other Health-Related Products

Dental/Vision/Hearing Products — Plans offering additional benefits for consumers who are looking to cover needs for dental, vision, or hearing. These plans **are not** affiliated or connected to Medicare.

Hospital Indemnity Products— Plans offering additional benefits; payable to consumers based upon their medical utilization; sometimes used to defray copays/coinsurance. These plans **are not** affiliated or connected to Medicare.

Medicare Supplement (Medigap) Products— Insurance plans that help pay some of the out-of-pocket costs not paid by Original Medicare (Parts A and B) such as deductibles and co-insurance amounts for Medicare approved services.