

Medicare Supplement Underwriting Questionnaire

You **do not** need to complete this form and return it to us. Please review the questions. If you can answer "no" to all the questions we would like to review your supplement coverage. If you answer "yes" to any of the questions we will be unable to switch your supplement at this time and will only review your prescription plan beginning later this month.

- | | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> |

medication.)
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c. Parkinson's disease, myasthenia gravis, cerebral palsy, muscular dystrophy, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's disease)?

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(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 |
|---|--------------------------|--------------------------|
| d. Paget's disease, rheumatoid arthritis, disabling arthritis, systemic lupus, osteoporosis with fractures, or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. diabetes with: neuropathy, retinopathy, vascular disease, or tobacco use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. major depression, bipolar disorder, schizophrenia, or a paranoid disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. dementia, senility, Alzheimer's disease, or organic brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | |
| k. unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| l. hepatitis (other than hepatitis A), alcohol or drug abuse, cirrhosis of the liver, or other liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | |
| m. stroke or transient ischemic attack (TIA)? | <input type="checkbox"/> | <input type="checkbox"/> |

Thank you again for taking the time to review these questions. Please respond to the email selecting the response that applies to you. We will be in touch as soon as possible if we are going to review your supplement.

If we are not reviewing your supplement or you wish to discuss the possibility of switching to an Advantage plan then we will review that during Annual Enrollment Period. We will be reviewing all prescription plans during Annual Enrollment Period as well.

You will hear from us at the end of September regarding the next phase of the review period.