

# FORETHOUGHT® Medicare Supplement

Underwriting guidelines

THINKING AHEAD<sup>SM</sup>

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## Contacts

### Addresses for mailing new business and delivery receipts

When mailing or shipping your new business applications, be sure to use the preaddressed envelopes.

#### *Administrative office mailing information*

##### **Mailing address**

Forethought Life Insurance Company  
Administrative office  
P.O. Box 14659  
Clearwater, FL 33766-4659

##### **Overnight/Express address**

Forethought Life Insurance Company  
Administrative office  
2536 Countryside Boulevard, Suite 501  
Clearwater, FL 33763

##### **FAX Number for New Business - ACH Applications**

1-855-808-0944

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## Questions? Call us at 1-877-492-5870

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### Introduction

This guide provides information about the evaluation process used in the underwriting and issuing of Medicare Supplement insurance policies. Our goal is to process each application as quickly and efficiently as possible while assuring proper evaluation of each risk. To ensure we accomplish this goal, the producer or applicant will be contacted directly by underwriting if there are any problems with an application.

### Policy issue guidelines

All applicants must be covered under Medicare Part A and B in Michigan, Texas and Washington; in all other states, only Part A is required. Policy issue is state specific. The applicant's state of residence controls the application, forms, premium and policy issue. If an applicant has more than one residence, the state where taxes are filed should be considered as the state of residence. Please refer to your introductory materials for required forms specific to your state.

#### **Open enrollment**

To be eligible for open enrollment, an applicant must be at least 64 ½ years of age (in most states) and be within six months of his/her enrollment in Medicare Part B.

Applicants covered under Medicare Part B prior to age 65 are eligible for a six-month open enrollment period upon reaching age 65.

#### **Additional Open Enrollment periods for Residents of the following state:**

**California** – Annual Open Enrollment lasting 90 days, beginning 60 days before and ending 30 days after the individual's birthday, during which time a person may replace any Medicare supplement policy with a policy of equal or lesser benefits. Coverage will not be made effective prior to the individual's birthday. Please include documentation verifying the Plan information and paid to date of the current coverage. If replacing a pre-standardized Plan, a copy of the current policy or policy schedule is required.

**Connecticut** – Year-round open enrollment.

**Maine** – One month open enrollment period every year in June for Plan A.

Individuals who have had a Medicare supplement plan or another health plan that supplements benefits provided by Medicare within 90 days are eligible for a plan that provides equal or lesser benefits. Please include documentation verifying the Plan information or the benefits of the coverage being replaced. Also be sure to include documentation showing the current coverage is in force or was in force within the last 90 days.

Applicants replacing a current 1990 standardized plan with a 2010 Modernized plan, may apply for a 2010 Modernized Medicare supplement plan of equal or lesser benefits and would **not** be subject to underwriting guidelines.

**Missouri** – Individuals that terminate a Medicare supplement policy within 30 days of the annual policy anniversary date may obtain the same plan on a guarantee issue basis from any issuer that offers that plan. This would include Medicare supplement and select plans. Please include documentation verifying the Plan information, paid-to-date and the policy anniversary of the current coverage. For policies with an effective date of 6/1/2010 or after, individuals with existing plans E, H, I and J can convert to one of the following plans: A, B, C, F, K or L.

**Vermont** – Year round open enrollment.

**Washington** – Individuals who currently have a standardized Medicare supplement plan may replace the plan as indicated below on an Open Enrollment basis.

- Persons with a Plan A may only move to another Plan A.
- Persons with a Plan B, C, D, E, F, G, M or N may move to any other Plan B, C, D, F (including high deductible), G, M, or N (Whether higher or lower in benefits compared to current plan.)
- Persons with a “Standardized” Plan H, I or J may move to another less comprehensive Plan B, C, D, F, G, M or N.
- Please include documentation verifying the Plan information and paid-to-date of the current coverage.

**Note:** Plans, E, H, I and J will no longer be available for new business as of June 1, 2010.

#### States with under age 65 requirements

<b>California</b>	Plans A & F available. Coverage is guarantee issue if applied for within six months of Part B enrollment. Not available for individuals with end stage renal disease.
<b>Colorado</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Connecticut</b>	Plans A and C are available.
<b>Delaware</b>	All plans are available only for individuals on Medicare due to end-stage renal disease. Coverage is guarantee issue if within six months of Part B enrollment.
<b>Florida</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Georgia</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment (effective 11/01/2010).
<b>Hawaii</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Illinois</b>	All Plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.

<b>Kansas</b>	All Plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Kentucky</b>	All Plans are available. No guarantee issue. All applications are underwritten.
<b>Louisiana</b>	All Plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Maine</b>	All Plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Maryland</b>	Plans A & C available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Minnesota</b>	Basic and Extended Basic plans available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Mississippi</b>	All Plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Missouri</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>New Hampshire</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>New Jersey</b>	Plan C available to people ages 50–64. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>North Carolina</b>	Plans A and C available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Oklahoma</b>	Plan A is available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Oregon</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Pennsylvania</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>South Dakota</b>	All Plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Tennessee</b>	All plans are available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Texas</b>	Plan A is available. Coverage is guarantee issue if applied for within six months of Part B enrollment.
<b>Vermont</b>	All plans are available. Not available for individuals with end stage renal disease.
<b>Wisconsin</b>	Base policy and riders are available. Coverage is guarantee issue if within six months of Part B enrollment.

### **Selective issue**

Applicants over the age of 65 and at least six months beyond enrollment in Medicare Part B will be selectively underwritten. All health questions must be answered. The answers to the health questions on the application will determine the eligibility for coverage. If any health questions are answered "Yes," the applicant is not eligible for coverage. Applicants will be accepted or declined. Elimination endorsements will not be used.

In addition to the health questions, the applicant's height and weight will be taken into consideration when determining eligibility for coverage. Coverage will be declined for those applicants who are outside the established height and weight guidelines.

Health information, including answers to health questions on applications and claims information, is confidential and is protected by state and federal privacy laws. Accordingly, Forethought Life Insurance Company does not disclose health information to any non-affiliated insurance company.

### **Application dates**

- Open Enrollment – Up to six months prior to the month the applicant turns age 65
- Underwritten Cases – Up to 60 days prior to the requested coverage effective date
- Connecticut – Year round enrollment. Applications may be taken up to 60 days prior to the requested coverage effective date.
- West Virginia – Applications may be taken up to 30 days prior to the month the applicant turns age 65
- Wisconsin – Applications may be taken up to 90 days prior to the month the applicant turns age 65.

### **Coverage effective dates**

Coverage will be made effective as indicated below:

1. Between age 64 ½ and 65 – The first of the month the individual turns age 65.
2. All Others – Application date or date of termination of other coverage, whichever is later.

### **Replacements**

A "replacement" takes place when an applicant terminates an existing Medicare Supplement/Select policy with a new Medicare Supplement/Select policy. Forethought Life Insurance Company requires a fully completed application when applying for a replacement policy (both internal and external replacements).

A policyowner wanting to apply for a non-tobacco Plan must complete a new application and qualify for coverage.

If an applicant has had a Medicare Supplement/Select policy issued by Forethought Life Insurance Company within the last 60 days, any new applications will be considered to be a replacement application. If more than 60 days has elapsed since prior coverage was in force, then applications will follow normal underwriting rules.

All replacements involving a Medicare Supplement, Select or Medicare Advantage Plan must include a completed Replacement Notice. One copy is to be left with the applicant; one copy should accompany the application. The replacement cannot be applied for on the exact same coverage and exact same company.

The replacement Medicare Supplement policy cannot be issued in addition to any other existing Medicare Supplement, Select or Medicare Advantage Plan.

### **Reinstatements**

When a Medicare Supplement policy has lapsed and it is within 90 days of the last paid to date, coverage may be reinstated, based upon meeting the underwriting requirements.

When a Medicare Supplement policy has lapsed and it is more than 90 days beyond the last paid to date, the coverage cannot be reinstated. The client may, however, apply for new coverage. All underwriting requirements must be met before a new policy can be issued.

### **Medicare Select to Medicare Supplement Conversion Privilege**

Policy owners covered under a Medicare Select Plan with Forethought Life Insurance Company may decide they no longer wish to participate in our hospital network. Coverage may be converted to one of our Medicare Supplement Plans not containing network restrictions. We will make available any Medicare Supplement policy offered in their state that provides equal or lesser benefits. A new application must be completed; however, evidence of insurability will not be required if the Medicare Select policy has been in force for at least six months at the time of conversion.

### **Telephone interviews**

Random telephone interviews with applicants will be conducted on underwritten cases. Please be sure to advise your clients that we may be calling to verify the information on their application.

### **Pharmaceutical information**

Forethought Life Insurance Company has implemented a process to support the collection of pharmaceutical information for underwritten Medicare Supplement applications. In order to obtain the pharmaceutical information as requested, please be sure to include a completed "Authorization to Release Confidential Medical Information (HIPAA)" form with all underwritten applications. This form can be found in the Application Packet. Prescription information noted on the application will be compared to the additional pharmaceutical information received. This additional information will not be solely used to decline coverage.

### **Policy delivery receipt**

Delivery receipts are required on all policies issued in Kentucky, Louisiana, Nebraska, South Dakota and West Virginia. Two copies of the delivery receipt will be included in the policy package. One copy is to be left with the client. The second copy must be returned to Forethought Life Insurance Company in the postage-paid envelope, which is also included in the policy package.

In Kentucky and Nebraska, if the policy is mailed directly to the insured, a signed and dated delivery receipt is not required.

## Guarantee issue rights for loss of Medicaid qualification

State	Guarantee issue situation	Client has the right to buy
CA	Client is enrolled in Medicare Part B, and as a result of an increase in income or assets, is no longer eligible for Medi-Cal benefits, or is only eligible for Medi-Cal benefits with a share cost and certify at the time of application that they have not met the share of cost.	<b>65 years or older</b> any Medigap plan offered by any issuer. <b>Under Age 65</b> Plans A and F. Not available for individuals with end stage renal disease.
KS	Client loses eligibility for health benefits under Medicaid.	any Medigap plan offered by any issuer.
OR	Client is enrolled in an employee welfare benefit plan or a state Medicaid plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates or the plan ceases to provide all such supplemental health benefits.	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.
TN	Client is enrolled under Medicaid and the enrollment involuntarily ceases after the individual is 65 years of age or older and eligible for and enrolled in Medicare Part B.	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.
TX	Client loses eligibility for health benefits under Medicaid.	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer; except that for persons under 65 years of age, it is a policy which has a benefit package classified as Plan A.
UT	Client is enrolled in Medicaid and is involuntarily terminated.	Medigap Plan A, B, C, F (including F with a high deductible), K or L offered by any issuer.
WI	Client is eligible for benefits under Medicare Parts A and B and is covered under the medical assistance program and subsequently loses eligibility in the medical assistance program.	Wisconsin's Basic Medicare supplement policy or certificate, along with any offered rider.

## Guarantee issue rights

The situation listed below can also be found in the Guide to Health Insurance.

Guarantee issue situation	Client has the right to buy
<p>Client is in the original Medicare Plan and has an employer group health Plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays. That coverage is ending.</p> <p>Note: In this situation, state laws may vary.</p>	<p>Medigap Plan A, B, C, F, K or L that is sold in client's state by any insurance company.</p> <p>If client has COBRA coverage, client can either buy a Medigap policy/certificate right away or wait until the COBRA coverage ends.</p>
<p>Client is in the original Medicare Plan and has a Medicare SELECT policy/certificate. Client moves out of the Medicare SELECT Plan's service area.</p> <p>Client can keep the Medigap policy/certificate or he/she may want to switch to another Medigap policy/certificate.</p>	<p>Medigap Plan A, B, C, F, K or L that is sold by any insurance company in client's state or the state he/she is moving to.</p>
<p>Client's Medigap insurance company goes bankrupt and the client loses coverage, or client's Medigap policy/certificate coverage otherwise ends through no fault of client.</p>	<p>Medigap Plan A, B, C, F, K or L that is sold in client's state by any insurance company.</p>

## Additional State Specific Guaranteed Issued Rights

<b>Connecticut</b>	All plans available for all guaranteed issue situations.
<b>Maine</b>	All plans available for all guaranteed issue situations.
<b>Minnesota</b>	Basic Plan and any combination of these riders: Part A Deductible, Part B Deductible, and Part B Excess for all Guarantee Issue situations.
<b>Vermont</b>	All plans available for all guaranteed issue situations.
<b>Washington</b>	Plan D is available for all guaranteed issue situations.
<b>Wisconsin</b>	All plans and riders available for all Guarantee Issue situations.

If you believe another situation exists, please contact the client's local "SHIP" office.

# Medicare Advantage (“MA”)

## Medicare Advantage (“MA”) Annual Election Period

General election periods for Medicare Advantage	Timeframe	Allows for
Annual Election Period (“AEP”)	Oct. 15th – Dec. 7th of every year	<ul style="list-style-type: none"><li>• Enrollment selection for a MA Plan</li><li>• Disenroll from a current MA Plan</li><li>• Enrollment selection for Medicare Part D</li></ul>
Medicare Advantage Disenrollment Period (“MADP”)	Jan. 1st – Feb. 14th of every year	<ul style="list-style-type: none"><li>• MA enrollees to disenroll from any MA plan and return to Original Medicare</li></ul> The MADP does not provide an opportunity to: <ul style="list-style-type: none"><li>• Switch from original Medicare to a Medicare Advantage Plan</li><li>• Switch from one Medicare to a Medicare Advantage Plan</li><li>• Switch from one Medicare Advantage Plan to another</li><li>• Switch from one Medicare Prescription Drug Plan to another</li><li>• Join, switch or drop a Medicare Medical Savings Account Plan</li></ul>

There are many types of election periods other than the ones listed above. If there is a question as to whether or not the MA client can disenroll, please refer the client to the local State Health Insurance Assistance Program (“SHIP”) office for direction.

### Medicare Advantage proof of disenrollment

If applying for a Medicare Supplement, Underwriting cannot issue coverage without proof of disenrollment. If a member disenrolls from Medicare, the MA Plan must notify the member of his/her Medicare Supplement guaranteed issue rights.

#### *Disenroll during AEP and MADP*

Complete the MA section on the Medicare Supplement application; and

1. Send ONE of the following with the application
  - a. A copy of the applicant’s MA Plan’s disenrollment notice
  - b. A copy of the letter the applicant sent to his/her MA Plan requesting disenrollment
  - c. A signed statement that the applicant has requested to be disenrolled from his/her MA Plan.

#### *If an individual is disenrolling outside AEP/MADP:*

1. Complete the MA section on the Medicare Supplement application; and
2. Send a copy of the applicant’s MA Plan’s disenrollment notice with the application.

For any questions regarding MA disenrollment eligibility, contact your SHIP office or call 1-800-MEDICARE, as each situation presents its own unique set of circumstances. The SHIP office will help the client disenroll and return to Medicare.

### Guaranteed issue rights

The situation listed below can also be found in the Guide to Health Insurance.

<b>Guaranteed issue situation</b>	<b>Client has the right to</b>
Client's MA Plan is leaving the Medicare program, stops giving care in his/her area, or client moves out of the Plan's service area	buy a Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company. Client must switch to original Medicare Plan.
Client joined a MA Plan when first eligible for Medicare Part A at age 65 and within the first year of joining, decided to switch back to original Medicare	buy any Medigap Plan that is sold in your state by any insurance company.
Client dropped his/her Medigap policy/certificate to join an MA Plan for the first time, has been in the Plan less than 2 years and wants to switch back	obtain client's Medigap policy/certificate back if that carrier still sells it. If his/her former Medigap policy/certificate is not available, the client can buy a Medigap Plan A, B, C, F, K or L that is sold in his/her state by any insurance company.
Client leaves an MA Plan because the company has not followed the rules or has misled the client	buy Medigap Plan A, B, C, F, K or L that is sold in the client's state by any insurance company.

### Forethought Life Insurance Company's guaranteed issue rights

<b>Guaranteed issue situation</b>	<b>Client has the right to</b>
Client's group health Plan ended and the client joined a MA Plan for the first time, has been in the Plan less than a year, and wants to switch back to original Medicare	buy any Medigap Plan except Plans G or N, that is sold in the client's state by Forethought Life Insurance Company.
Client voluntarily left group health Plan and wants to purchase a Medicare Supplement	buy any Medigap Plan except Plans G or N, that is sold in the client's state by Forethought Life Insurance Company.

If the applicant(s) falls under one of the Guarantee Issue situations outlined above, proof of eligibility must be submitted with the application. In addition to the documents identified above, proper proof may include a letter of credible coverage from the previous carrier or a letter from the applicant's employer.

## Premium

### Calculating premium

#### *Utilize Outline of Coverage*

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if tobacco or non-tobacco use
- Find age/gender - Verify that the age and date of birth are the exact age as of the application date
- This will be your base monthly premium

*Tobacco rates do not apply during open enrollment or guarantee issue situations in the following states:*

Arkansas	Louisiana	North Carolina	Virginia
Colorado	Maryland	North Dakota	Vermont*
Connecticut*	Michigan	Ohio	Washington*
Iowa	Missouri	Pennsylvania	Wisconsin
Illinois	New Hampshire	Tennessee	
Kentucky	New Jersey	Utah	

*\*Tobacco rates never apply in Connecticut, Vermont or Washington.*

### Types of Medicare policy ratings

- **Community rated** – The same monthly premium is charged to everyone who has the Medicare policy, regardless of age. Premiums are the same no matter how old the applicant is. Premiums may go up because of inflation and other factors, but not based on age.
- **Issue-age rated** – The premium is based on the age the applicant is when the Medicare policy is bought. Premiums are lower for applicants who buy at a younger age, and won't change as they get older. Premiums may go up because of inflation and other factors, but not because of applicant's age.
- **Attained-age rated** – The premium is based on the applicant's current age so the premium goes up as the applicant gets older. Premiums are low for younger buyers, but go up as they get older. In addition to change in age, premiums may also go up because of inflation and other factors.

## Rate type available by state

State	Tobacco / non-tobacco rates	Gender rates	Attained, issue or community rated	Tobacco rates during open enrollment	Enrollment/ policy fee
AK	Y	Y	A	Y	Y
AL	Y	Y	A	Y	Y
AR	Y	N	C	N	N
AZ	Y	Y	I	Y	Y
CA	Y	N	A	Y	Y
CO	Y	Y	A	N	Y
CT	N	N	C	N	N
DE	Y	Y	A	Y	Y
FL	Y	Y	I	Y	Y
HI	Y	Y	A	Y	Y
GA	Y	Y	I	Y	Y
IA	Y	Y	A	N	Y
ID	Y	N	I	Y	Y
IL	Y	Y	A	N	Y
IN	Y	Y	A	Y	Y
KS	Y	Y	A	Y	Y
KY	Y	Y	A	N	Y
LA	Y	Y	A	N	Y
MD	Y	Y	A	N	Y
ME	Y	N	C	Y	N
MI	Y	Y	A	N	Y
MN	Y	N	C	Y	N
MO	Y	Y	I	N	Y
MS	Y	Y	A	Y	Y
MT	Y	N	A	Y	Y
NC	Y	Y	A	N	Y
ND	Y	Y	A	N	Y
NE	Y	Y	A	Y	Y
NH	Y	Y	I	N	Y
NJ	Y	Y	A	N	Y
NM	Y	Y	A	Y	Y
NV	Y	Y	A	Y	Y
OH	Y	Y	A	N	Y
OK	Y	Y	A	Y	Y
OR	Y	Y	A	Y	Y
PA	Y	Y	A	N	Y
RI	Y	N	A	Y	Y
SC	Y	Y	A	Y	Y
SD	Y	Y	A	Y	Y
TN	Y	Y	A	N	Y
TX	Y	Y	A	Y	Y
UT	Y	Y	A	N	Y
VA	Y	Y	A	N	Y
VT	N	N	C	N	N
WA	N	N	C	N	N
WI	Y	Y	A	N	Y
WV	Y	Y	A	Y	N
WY	Y	Y	A	Y	Y

## Height and weight chart

### Eligibility

To determine whether your client may purchase coverage, locate their height, then weight in the chart below. If their weight is in the Decline column, we're sorry, they're not eligible for coverage at this time. If their weight is located in the Standard column, continue to step 1.

Height	Decline weight	Standard weight	Decline weight
4' 2"	< 54	54 – 145	146 +
4' 3"	< 56	56 – 151	152 +
4' 4"	< 58	58 – 157	158 +
4' 5"	< 60	60 – 163	164 +
4' 6"	< 63	63 – 170	171 +
4' 7"	< 65	65 – 176	177 +
4' 8"	< 67	67 – 182	183 +
4' 9"	< 70	70 – 189	190 +
4' 10'	< 72	72 – 196	197 +
4' 11"	< 75	75 – 202	203 +
5' 0"	< 77	77 – 209	210 +
5' 1"	< 80	80 – 216	217 +
5' 2"	< 83	83 – 224	225 +
5' 3"	< 85	85 – 231	232 +
5' 4"	< 88	88 – 238	239 +
5' 5"	< 91	91 – 246	247 +
5' 6"	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8"	< 99	99 – 269	270 +
5' 9"	< 102	102 – 277	278 +
5' 10"	< 105	105 – 285	286 +
5' 11"	< 108	108 – 293	294 +
6' 0"	< 111	111 – 302	303 +
6' 1"	< 114	114 – 310	311 +
6' 2"	< 117	117 – 319	320 +
6' 3"	< 121	121 – 328	329 +
6' 4"	< 124	124 – 336	337 +
6' 5"	< 127	127 – 345	346 +
6' 6"	< 130	130 – 354	355 +
6' 7"	< 134	134 – 363	364 +
6' 8"	< 137	137 – 373	374 +
6' 9"	< 140	140 – 382	383 +
6' 10"	< 144	144 – 392	393 +
6' 11"	< 147	147 – 401	402 +
7' 0"	< 151	151 – 411	412 +
7' 1"	< 155	155 – 421	422 +
7' 2"	< 158	158 – 431	432 +
7' 3"	< 162	162 – 441	442 +
7' 4"	< 166	166 – 451	452 +

### **Enrollment/Policy Fee**

There will be a one-time application fee of \$25.00 (\$6.00 in Mississippi) that will be collected with each applicant's initial payment. For a husband and wife written on the same application, \$50 in fees must be collected. This will not affect the renewal premiums. The application fee does not apply in Arkansas, Connecticut, Maine, Minnesota, West Virginia or Washington.

### **Completing the Premium on the Application**

Premiums are calculated based upon the applicants exact age at the time of application, not their age as of the requested coverage effective date.

#### *Initial Premium*

- Enter the initial Premium Collected in the box located on the application.

#### *Renewal Premium*

- Determine how the client wants to be billed going forward (renewal) and select the appropriate mode on the Renewal Premium Mode section on the application.
- Indicate, based on the mode selected, the renewal premium. Monthly direct billing is not allowed.

NOTE: If utilizing Electronic Funds Transfer ("EFT") as a method of payment, please complete Section 5 of the application. If paying the initial premium by EFT, the completed authorization form must be complete and submitted with the application. The policy will NOT be issued without this authorization.

### **Collection of Premium**

At least one month's premium must be submitted with the application. If a mode other than monthly is selected, then the full modal premium must be submitted with the application.

*NOTE: Forethought Life Insurance Company does not accept post-dated checks or payments from Third Parties, including any Foundations as premium for Medicare Supplement/Select.*

### **Notices and Initial Premium Receipt**

Complete this page as requested. Leave this page of the application package with the applicant.

*NOTE: Do not mail a copy of the receipt with the application.*

**Shortages**

Forethought Life Insurance Company will communicate with the producer by telephone, e-mail or FAX in the event of a premium shortage. The application will be held in a pending status until the balance of the premium is received. Producers may communicate with Underwriting by calling 1-877-492-5870 or by FAX at 1-855-808-0944.

**Refunds**

Forethought Life Insurance Company will make all refunds to the applicant in the event of rejection, incomplete submission, overpayment, cancellations, etc.

**Our General Administrative Rule – 12 Month Rate**

Our current administrative practice is not to adjust rates for 12 months from the effective date of coverage.

# Application

Properly completed applications should be finalized within 5-7 days of receipt at Forethought Life Insurance Company's administrative office. The ideal turnaround time provided to the producer is 11-14 days, including mail time.

## Application sections

The Medicare Supplement application consists of six sections that must be completed. Please be sure to review your applications for the following information before submitting.

### Plan Information section

- Entire Section must be completed
- This section should indicate the Plan or policy form selected, effective date, premium paid, and the premium payment mode selected – both initial and renewal

*Note: The effective date cannot be on the 29th, 30th, or 31st of the month.*

### Section 1 – Applicant information

- Please complete the client's residence address in full. If premium notices are to be mailed to an address other than the applicant's residence address, please complete the mailing address in full
- Age and Date of Birth are the exact age as of the application date
- Medicare Card number, also referred to as the Health Insurance Claim ("HIC") number, is required for electronic claims payment
- Height/Weight – This is required on underwritten cases
- Answer the tobacco question. (Refer to the Calculating Premium section in this guide for a list of states where tobacco rates do not apply during open enrollment or guarantee issue situations)

### Section 2 – Miscellaneous questions

- Verify the applicant answered "Yes" to receiving the Guide to Health Insurance and Outline of Coverage, it is required to leave these two documents with the client at the time the application is completed
- Please indicate if the applicant is covered under Parts A and B of Medicare

### **Section 3 – Insurance policies**

- If the applicant is applying during a guarantee issue period, be sure to include proof of eligibility
- If the applicant is replacing another Medicare Supplement policy/certificate, complete question #2 and include the replacement notice
- If the applicant is leaving a Medicare Advantage Plan, complete question #3 and include the replacement notice
- If the applicant has had any other health insurance coverage in the past 63 days, including coverage through a union, employer Plan, or other non-Medicare Supplement coverage, complete question #4
- Verify if the applicant is covered through his/her state Medicaid program

### **Section 4 – Health questions**

- If the applicant is applying during an open enrollment or a guarantee issue period, do not answer the health questions or prescription information
- If applicant is not considered to be in open enrollment or a guarantee issue situation, all health questions must be answered, including the question regarding prescription medications

*NOTE: In order to be considered eligible for coverage, all health questions must be answered "No".*

For questions on how to answer a particular health question, see the Health Questions section of this guide for clarification.

### **Section 5 – Billing information**

- To establish premium payments by EFT ("Electronic Funds Transfer"), complete entirely and submit.

### **Section 6 – Signatures**

- Signatures and dates: required by both applicant(s) and producer. The producer must be appointed in the state where the application is signed

*NOTE: Applicant's signature must match name of applicant on the application. In rare cases where applicant cannot sign his/her name, a mark ("X") is acceptable if accompanied by a witness signature. For their own protection, the producer does not qualify as a witness.*

- If someone other than the applicant is signing the application (i.e., Power of Attorney), please include copies of the papers appointing that person as the legal representative

## Health questions

Unless an application is completed during open enrollment or a guarantee issue period, all health questions, including the question regarding prescription medications, must be answered. Our general underwriting philosophy is to deny Medicare Supplement coverage if any of the health questions are answered "Yes." For a list of uninsurable conditions and the related medications associated with these conditions, please refer to the next sections in this guide.

There may, however, be situations where an applicant has been receiving medical treatment or taking prescription medication for a long-standing and controlled health condition. Those conditions are listed in health questions 8, 9 and 10.

A condition is considered to be controlled if there have been no changes in treatment or medications for at least two years. If this situation exists and you would like consideration to be given to the application, answer the appropriate question "Yes," and attach an explanation stating how long the condition has existed and how it is being controlled. Be sure to include the names and dosages of all prescription medications.

If you have questions about the interpretation of health questions 6 and 7 on the application, please see the information below.

### Health questions 6 and 7 on the application:

People with diabetes mellitus that require, or have ever required, more than 50 units of insulin daily, or people with diabetes (insulin dependent or treated with oral medications) who also have one or more of the complicating conditions listed in question 6 on the application, are not eligible for coverage. For purposes of this question, hypertension (high blood pressure) is considered a heart condition. Some additional questions to ask your client to determine if he/she does have a complication include:

1. Does he/she have eye/vision problems?
2. Does he/she have numbness or tingling in the toes or feet?
3. Does he/she have problems with circulation? Pain in the legs?

Consideration for coverage may be given to those persons with well-controlled cases of hypertension and diabetes. A case is considered to be well controlled if the person is taking less than 50 units of insulin daily or no more than two oral medications for diabetes and no more than two medications for hypertension. A combination of less than 50 units of insulin a day and one oral medication would be the same as two oral medications if the diabetes were well controlled. In general, to verify stability, there should be no changes in the dosages or medications for at least two years. Individual consideration will be given where deemed appropriate. We consider hypertension to be stable if recent average blood pressure readings are 150/85 or lower.

**Health question 8 on the application:**

Malignant Melanoma is considered an internal cancer. Applicants with this type of cancer are not eligible for coverage. Other types of cancer, such as basal cell, are not considered internal.

**Uninsurable health conditions**

Applications should not be submitted if applicant has the following conditions:

AIDS	Emphysema
Alzheimer's Disease	End-stage Renal Disease ("ESRD")
ARC	Kidney disease requiring dialysis
Cirrhosis	Lateral Sclerosis ("ALS")
Chronic Obstructive Pulmonary Disease ("COPD")	Lupus - Systemic
Other chronic pulmonary disorders to include:	Multiple Sclerosis
Chronic bronchitis	Myasthenia Gravis
Chronic obstructive lung disease ("COLD")	Organ transplant
Chronic asthma	Osteoporosis with fracture
Chronic interstitial lung disease	Parkinson's Disease
Chronic pulmonary fibrosis	Senile Dementia
Cystic fibrosis	Other cognitive disorders to include:
Sarcoidosis	Mild cognitive impairment ("MCI")
Bronchiectasis	Delirium
Scleroderma	Organic brain disorder
Diabetes - Insulin >50 units/day	Spinal Stenosis

In addition to the above conditions, the following will also lead to a decline:

- Implantable cardiac defibrillator
- Use of supplemental oxygen
- Use of a nebulizer
- Asthma requiring continuous use of three or more medications including inhalers
- Taking any medication that must be administered in a physician's office
- Advised to have surgery, medical tests, treatment or therapy
- If applicant's height/weight is in the decline column on the chart

## Partial list of medications associated with uninsurable health conditions

This list is not all-inclusive. An application should not be submitted if a client is taking any of the following medications:

3TC	AIDS	Megestrol	Cancer
Alkeran	Cancer	Mellaril	Psychosis
Amantadine	Parkinson's Disease	Melphalan	Cancer
Apokyn	Parkinson's Disease	Memantine	Alzheimer's Disease
Aptivus	HIV	Methotrexate (>25mg/wk)	Rheumatoid Arthritis
Aricept	Dementia	Metrifonate	Dementia
Artane	Parkinson's Disease	Mirapex	Parkinson's Disease
Atripla	HIV	Myleran	Cancer
Avonex	Multiple Sclerosis	Namenda	Alzheimer's Disease
Azilect	Parkinson's Disease	Natrecor	CHF
AZT	AIDS	Navane	Psychosis
Baclofen	Multiple Sclerosis	Nelfinavir	AIDS
BCG	Bladder Cancer	Neoral	Immunosuppression, Severe Arthritis
Betaseron	Multiple Sclerosis		
Cerefolin	Dementia	Neupro	Parkinson's Disease
Carbidopa	Parkinson's Disease	Norvir	HIV
Cogentin	Parkinson's Disease	Novatrone	Multiple Sclerosis
Cognex	Dementia	Paraplatin	Cancer
Combivir	HIV	Parlodel	Parkinson's Disease
Comtan	Parkinson's Disease	Permax	Parkinson's Disease
Copaxone	Multiple Sclerosis	Prednisone (>10 mg/day)	Rheumatoid Arthritis, COPD
Crixivan	HIV		
Cytosan	Cancer, Severe Arthritis, Immunosuppression	Prezista	HIV
		Procrit	Kidney Failure, AIDS
D4T	AIDS	Prolixin	Psychosis
DDC	AIDS	Razadyne	Dementia
DDI	AIDS	Remicade	Rheumatoid Arthritis
DES	Cancer	Reminyl	Dementia
DuoNeb	COPD	Remodulin	Pulmonary Hypertension
Eldepryl	Parkinson's Disease	Requip	Parkinson's Disease
Embrex	Rheumatoid Arthritis	Rescriptor	HIV
Emtriva	HIV	Retrovir	AIDS
Epivir	HIV	Rebif	Multiple Sclerosis
Epogen	Kidney Failure, AIDS	Reyataz	HIV
Ergoloid	Dementia	Riluzole	ALS
Exelon	Dementia	Risperdal	Psychosis

Fuzeon	HIV	Ritonavir	AIDS
Galantamine	Dementia	Sandimmune	Immunosuppression, Severe Arthritis
Geodon	Schizophrenia		
Gold	Rheumatoid Arthritis	Selzentry	HIV
Haldol	Psychosis	Sinemet	Parkinson's Disease
Herceptin	Cancer	Stalevo	Parkinson's Disease
Hydergine	Dementia	Stelazine	Psychosis
Hydrea	Cancer	Sustiva	AIDS
Hydroxyurea	Melanoma, Leukemia, Cancer	Symmetrel	Parkinson's Disease
		Tacrine	Dementia
Imuran	Immunosuppression, Severe Arthritis	Tasmar	Parkinson's Disease
		Teslac	Cancer
Insulin (>50 units/day)	Diabetes	Thiotepa	Cancer
Interferon	AIDS, Cancer, Hepatitis	Thorazine	Psychosis
Indinavir	AIDS	Trelstar-LA	Prostate Cancer
Invega	Schizophrenia	Trizivir	HIV
Invirase	AIDS	Truvada	HIV
Kaletra	HIV	Tysabri	Multiple Sclerosis
Kemadrin	Parkinson's Disease	Valycte	CMV HIV
Lasix / Furosemide (>60 mg/day)	Heart Disease	VePesid	Cancer
		Videx	HIV
L-Dopa	Parkinson's Disease	Vincristine	Cancer
Letairis	Pulmonary Hypertension	Viracept	HIV
Leukeran	Cancer, Immunosuppression, Severe Arthritis	Viramune	AIDS
		Viread	HIV
		Zanosar	Cancer
Levodopa	Parkinson's Disease	Zelapar	Parkinson's Disease
Lexiva	HIV	Zerit	HIV
Lioresal	Multiple Sclerosis	Ziagen	HIV
Lomustine	Cancer	Ziprasidone	Schizophrenia
Lupron	Cancer	Zoladex	Cancer
Megace	Cancer	Zometa	Hypercalcemia in Cancer

## Mailing applications to prospects

Mailing a completed application adds a few steps to the normal sales process. Below is a description of the necessary steps.

### The Facts

#### *When face-to-face interviews aren't possible*

Face-to-face interviews are always preferable, however, there will be times when you cannot meet with prospects in person. When necessary, and with the prospect's consent, you may conduct the interview over the phone and mail the completed application to the prospect.\*

This option is to be used only with people who have responded to lead-generation material or with whom you have ongoing client relationships. It is not appropriate for cold calling as national and corporate do-not-call rules and other compliance requirements apply.

#### *The sales process*

The method for selling Medicare Supplements doesn't change: Call a lead, review coverage, ask for the sale, complete and sign the application, submit the business, deliver the policy. The difference is that parts of the sales process may be conducted via the telephone instead of face-to-face. Consequently, there are a few more steps, outlined on the next two pages, to complete the sale.

#### *Improve time service*

Submitting complete and accurate information ensures quick timely service. Other factors are:

- You must be licensed to sell in the state where the prospect is a resident
- If an application is taken on a Kansas resident, the producer must be appointed in Kansas and in the state where the application is signed.
- The producer who solicits the business must sign the corresponding application
- You cannot sign blank applications
- It is not acceptable to mail blank applications, brochures and outlines as prospecting material

#### *Spot check for customer satisfaction*

To ensure that customers who complete Medicare Supplement applications over the phone perceive this process as positive and that it's followed correctly, Forethought Life Insurance Company will call a portion of these applicants to:

- Verify the content and accuracy of the information submitted
- Determine their overall satisfaction level
- Confirm that producers followed this process

\*Applies only to Forethought Life Insurance Company's Medicare Supplement products and does not change the current underwriting requirements for other Forethought Life Insurance Company products.

## The Process

Please complete the following steps when you conduct the Medicare Supplement sales interview over the phone and mail the completed application to the prospect:

*Step 1 – Call the prospect that responded to a lead.*

When you receive a lead, telephone the person to discuss the benefits, rates and answer questions. Attempt to schedule a face-to-face appointment to review details, ask for the sale and apply for coverage.

If the prospect prefers to continue the sales process on the phone, continue to Step 2.

*Note: You must be licensed to sell in the state where the prospect is a resident.*

*Step 2 – Communicate the process.*

If the prospect wants coverage and prefers to apply for a policy over the phone instead of in person, explain the process before proceeding to Step 3:

1. Producer asks the prospect the questions on the application and required forms.
2. Producer mails the completed application and forms to the prospect for review and his/her signature.
3. Prospect carefully reviews the application and forms for completeness and accuracy and signs them.
4. Prospect returns the application, forms and premium in the provided postage-paid envelope.
5. Producer verifies all the required forms are completed and signed.
6. Producer submits the application and required forms through the usual channel.
7. When issued, the producer delivers the policy according to current policy delivery guidelines.

*Step 3 – Complete the required forms over the telephone.*

Ask the prospect all the questions on the application, replacement notice and state special forms (if needed) and print the answers. Repeat his/her responses for accuracy.

*Note: Privacy requirements prohibit discussing eligibility for other products over the telephone.*

*Step 4 – Mail forms to the prospect.*

Place the following in an envelope and mail to the prospect:

- Cover letter (attach your business card):
  - Indicating which forms to sign and what to return to you
  - Asking the prospect to verify all information including his/her Medicare card number, to make necessary corrections and initial changes
  - Inviting the prospect to contact you with any questions
- Application and forms (replacement notice and state special forms, if needed) with signature areas and premium highlighted
- Outline of Coverage, Guide to Health Insurance for People with Medicare
- Postage-paid addressed envelope

*Note: Plan availability and premium rates are based on when the application is signed. The producer must communicate changes in Plan availability or premium to the prospect before submitting the forms to Forethought Life Insurance Company.*

*Step 5 – Prospect reviews and signs forms.*

Once the prospect receives the application and forms, he/she:

- Verifies the responses and initials any corrections
- Signs the application and forms as highlighted
- Returns the application and forms to the producer in the provided envelope

*Step 6 – Verify and sign forms.*

When you receive the envelope from the prospect, you:

- Check that you have the first premium payment and the completed and signed application and forms
- Verify that the prospect initialed any changes
- Sign the required items
- Send the Premium Receipt to the applicant

*Note: The producer who solicited the business must sign the application.*

*Step 7 – Submit for processing.*

Submit the business (application and forms) in the usual manner as noted in the application pack.

*Step 8 – Deliver the policy according to current policy delivery guidelines.*

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**Questions? Call us at 1-877-492-5870**

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## Required forms

### Application

Only current Medicare Supplement applications may be used in applying for coverage. A copy of the completed application will be made by Forethought Life Insurance Company and attached to the policy to make it part of the contract.

The agent is responsible for submitting completed applications to Forethought Life Insurance Company's administrative office.

### Agent Certification

This form must be signed by the agent and the applicant(s) and returned with the application.

### Authorization to release confidential medical information or HIPAA authorization form

The HIPAA form must have a current and clearly written date. It is required with all underwritten applications.

### Calculate your Premium

This form is used to calculate the correct premium and must be returned with the application.

### Notices and initial receipt and notice of information practices

Receipt must be completed and provided to applicant as receipt for premium collected. Notice must be provided to applicant.

### Replacement form(s)

The replacement form(s) must be signed and submitted with the application when replacing any Medicare Supplement or Medicare Advantage application. A signed replacement notice must be left with the applicant; a second signed replacement notice must be submitted with the application.

### Select Disclosure Agreement

The Select Disclosure Agreement form must be signed and submitted with the application when a Select Plan is chosen (Select Plan not available in all states).

### Delivery Receipt

The following states require a delivery receipt: Kentucky, Louisiana, Nebraska, South Dakota and West Virginia. Where no preference is made the policy will be sent to the producer.

In Kentucky and Nebraska, if the policy is mailed directly to the insured, a signed and dated delivery receipt is not required.

## State special forms

Forms specifically mandated by states to accompany point of sale material.

### Arkansas

**Documentation of Solicitation of Medicare Related Products form** –Form must be completed and retained in applicant's file.

### California

**California Agent/Applicant Meeting Form** – To be completed and signed by Forethought Life Insurance Company's representative and given to applicant when a meeting to discuss Medicare supplement insurance is scheduled.

**Guarantee Issue and Open Enrollment Notice for California** – This form includes the requirements for individuals who are eligible for Guarantee Issue. This form must be read and signed by the Applicant and Agent. A copy must be submitted with the application and a copy left with the Applicant.

### ***Colorado***

**Commission Disclosure Form** – This form is to be completed by the Agent, then signed by the Agent and Applicant. Leave a copy with the Applicant and retain a copy in the applicant's file.

### ***Florida***

**Florida Certification Form** – This form is to be completed by the Agent, then signed by the Agent and Applicant. A copy must be submitted with the application and a copy left with the Applicant.

### ***Illinois***

**Medicare Supplement Checklist** – The Checklist must be completed and submitted with the application and a copy left with the applicant.

### ***Iowa***

**Important Notice before You Buy Health Insurance** – To be left with the Applicant.

### ***Kentucky***

**Medicare Supplement Comparison Statement** – Form should be completed when replacing a Medicare supplement or Medicare Advantage plan.

### ***Louisiana***

**Your Rights Regarding the Release and Use of Genetic Information** – This form is to be left with the Applicant.

### ***Minnesota***

**Agent Information Form** – This form is to be completed and signed by the Agent and left with the applicant.

### ***Montana***

**Privacy Notice** – This form is to be left with the Applicant.

### ***Nebraska***

**Senior Health Counseling Notice** – This form is to be left with the Applicant.

### ***New Mexico***

**New Mexico Confidential Abuse Information** – Optional form, submit copy if completed.

### ***Pennsylvania***

**Guarantee Issue and Open Enrollment Notice** – To be left with the Applicant.

### ***Texas***

**Definition of Eligible Person for Guaranteed Issue Notice** – This notice must be provided to the client.

### ***Wisconsin***

**Disclosure of Other Health Insurance Sold to Applicant by Agent** – To be completed and signed by the Agent, then submitted with the application.

**Forethought Life Insurance Company**

**Administrative office**

PO Box 14659  
Clearwater, FL 33766-4659

Phone: 1-877-492-5870

***[www.forethought.com](http://www.forethought.com)***

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