

# Sterling Fax Application Transmittal Cover Sheet

**Important:**

- Only applications paying the initial premium by bank draft are eligible to be faxed.
- DO NOT collect premium with an application that is being faxed.
- All applications submitted with this form must be written by the same agent.
- No more than 5 applications are to be faxed with this Cover Sheet.
- Do not mail in applications/forms once you have faxed them, original copies should be maintained in case of fax transmission problems.
- It is important to include phone/fax number below. Agents will be contacted if premium amount on Fax cover sheet does not match our premium calculation when the application is processed.
- If commissions are to be split between two agents – both agents' information must be listed in the **Agent's Certification** section of the application.
- If additional documents are requested (2<sup>nd</sup> applications, replacement forms or other forms), the requested information should be faxed to 1-866-919-4351 (please include application # on the fax).

\*\*\*IMPORTANT Applications faxed to the wrong fax number could cause processing delays\*\*\*

New Business Fax Number when telephone interview was **NOT** completed at point of sale: 1-866-920-4351.

New Business Fax Number when telephone interview was completed at point of sale: 1-866-919-4351.

**All documentation faxed to this number MUST have an application number written on the document.**

As a confirmation that your applications were received, a copy of this form stamped "APPLICATIONS RECEIVED" will be faxed back to the agent within 24 hours of receipt of the Application(s). **Do Not** refax applications/forms unless asked to do so.

Agent Name: \_\_\_\_\_ Agent Writing # \_\_\_\_\_

Phone Number: \_\_\_\_\_ Agent Fax Number: \_\_\_\_\_

Total number of pages being faxed (including cover sheet): \_\_\_\_\_

Forms sequence:

1. Application
2. Replacement form (if applicable)
3. Other state specific required forms (if applicable)
4. Guaranteed Issue documentation (if applicable)
5. Signed Bank Draft Authorization
6. Copy of a voided check or deposit slip (**on separate piece of paper, DO NOT attach to the Bank Draft Authorization**)

Applicant First, Last Name	Plan Applied For:	Initial Premium Amount to be Drafted (include policy fee)	Application Number (Provided at Point of Sale, if applicable)

All application questions should be directed to the Underwriting Department at 1-877-604-5240.

**STERLING INVESTORS LIFE INSURANCE COMPANY**

Home Office: Rome, Georgia  
Administration: P.O. Box 10846  
Clearwater, Florida 33757-8846

**APPLICATION FOR MEDICARE SUPPLEMENT COVERAGE**

**SECTION A. PROPOSED INSURED INFORMATION**

Applicant Name *(exactly as it appears on your Medicare card)*

Resident Address

Phone *(with area code)*

City

State, Zip Code

Date of Birth *mm/dd/yyyy*

Current Age

Male  Female

Social Security No

Medicare Card No

Email Address

Height *Feet and inches*

Weight *Pounds*

**SECTION B. PLAN AND PREMIUM INFORMATION**

Plan

Requested Policy Effective Date

Premium Collected \$

Initial Bank Draft: Issue Date  Effective Date

Payment Mode: Monthly Bank Draft  Annual  Semi-Annual  Quarterly

**SECTION C. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS**

- |  |  |
|--|--|
| 1. Have you used tobacco in any form in the past 12 months?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Are you covered under Medicare Part A?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If YES, what is your Part A effective date?      /    /  |  |
| If NO, what is your eligibility date?            /    /  |  |
| 3. Are you covered under Medicare Part B?  | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If YES, what is your Part B effective date?      /    /  |  |
| If NO, what is your eligibility date?            /    /  |  |
| 4. Are you applying during a guaranteed issue period? (If YES please attach proof of eligibility). | Yes <input type="checkbox"/> No <input type="checkbox"/> |

## SECTION D. HEALTH QUESTIONS

If applying during Open Enrollment or a Guaranteed Issue period, go to SECTION F.

If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. If you answer YES to any of the following questions 1 - 14, you are not eligible for coverage.

1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes  No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? Yes  No
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? Yes  No
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? Yes  No
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes  No
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), or kidney disease? If you do **not** have diabetes, this question should be answered "NO." Yes  No
7. Do you have diabetes that has ever required more than 50 units of insulin daily? Yes  No
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? Yes  No
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? Yes  No
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? Yes  No
11. Have you been advised by a physician that surgery may be required within twelve (12) months for cataracts? Yes  No
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? Yes  No
13. Have you been hospital confined three or more times in the last two years? Yes  No
14. Have you had an organ transplant or been advised by a physician to have an organ transplant? Yes  No

**SECTION E. MEDICATION HISTORY**

Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months?

Yes  No

If YES, please list the drug(s) and the condition(s) below. Attach a separate sheet if needed.

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

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Diagnosis/Condition

Medication Name (copy off pharmacy label)

Date **Originally** Prescribed

Dosage and Frequency

Diagnosis/Condition

**SECTION F. FOR YOUR PROTECTION**, the National Association of Insurance Commissioners require that we ask the following questions about insurance policies or certificates you may have.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.**

To the Best of Your Knowledge:

1. (a) Did you turn age 65 in the last six months? Yes  No   
 (b) Did you enroll in Medicare Part B in the last six months? Yes  No   
 (c) If YES, indicate your effective date. / /

2. Are you covered for medical assistance through the state Medicaid program? Yes  No   
 (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)  
 If YES, answer (a) – (b) below.  
 (a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes  No   
 (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes  No

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days? (For example, a Medicare Advantage plan, or a Medicare HMO or PPO.) Yes  No   
 If YES, answer (a) – (g) below.  
 (a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Coverage Dates: START DATE / /  
 (if you are still covered under this plan, leave end date blank) END DATE / /  
 (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes  No   
 If YES, have you received a copy of the replacement notice? Yes  No   
 (c) Reason for termination/disenrollment? \_\_\_\_\_  
 (d) Planned date of termination/disenrollment? / /  
 (e) Was this your first time in this type of Medicare plan? Yes  No   
 (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes  No   
 (g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes  No

4. Do you have another Medicare supplement or Medicare select insurance policy in force? Yes  No   
 If YES, answer (a) – (d) below.  
 (a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Issue Date / /  
 (b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes  No   
 (c) Indicate termination date. / /  
 (d) Have you received a copy of the replacement notice? Yes  No

**SECTION F. (continued)**

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes  No   
 If YES, answer (a) – (c) below.

(a) Name of Company \_\_\_\_\_  
 Plan Type & Policy/Certificate No \_\_\_\_\_  
 Company Telephone Number \_\_\_\_\_  
 Coverage Dates: START DATE / /  
 (if you are still covered under this plan, leave end date blank) END DATE / /  
 (b) Reason for termination/disenrollment? \_\_\_\_\_  
 (c) Planned date of termination/disenrollment? / /

**This section to be completed by an agent.**

Agents shall list any other health insurance policies they have sold to the applicant.

(1) List policies sold which are still in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

(2) List policies sold in the past five (5) years which are no longer in force.

Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage
Name of Company
Policy/Certificate Number
Description of Benefits
Effective Date of Coverage

## IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available a substantially equivalent policy) will be reinstated, if requested, within 90 days of losing your employer or union based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy 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).

## AUTHORIZATION AND CERTIFICATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or Medicare, that has any records or knowledge of me or my health to give Sterling Investors Life Insurance Company, or its reinsurers, any such information. I understand that I am authorizing Sterling Investors Life Insurance Company to receive my health information and prescription drug usage history. The released information received by Sterling Investors Life Insurance Company will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information. Medical information will not be used to decline coverage if I am applying during an open enrollment or guaranteed issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with Sterling Investors Life Insurance Company. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to Sterling Investors Life Insurance Company *will* result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying Sterling Investors Life Insurance Company in writing at their Medicare Supplement Administrative Office: P.O. Box 10846, Clearwater, Florida 33757-8846. I understand that such revocation will not have any effect on actions Sterling Investors Life Insurance Company took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, or change in policy benefits. A photocopy of this authorization will be treated in the same manner as the original. I understand that I or my authorized representative am entitled to a copy of this authorization.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing. The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

**Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.**

I wish to apply for a Medicare supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: \_\_\_\_\_  
                    State                      Applicant's Signature                      Date

### This section to be completed by an agent.

I certify that I have truly and accurately recorded the information supplied by the Applicant.

Signed at: \_\_\_\_\_  
                    State                      Agent's Signature                      Date

Policy Mailing Preference:     Mail to Agent     Mail to Applicant

# STERLING INVESTORS LIFE INSURANCE COMPANY

Administrative Office  
8545 126th Avenue N. Ste 200  
Largo, FL 33773-1502

1. Attach voided check
2. Date and sign this authorization below

As a convenience to me, I hereby request and authorize you to pay and charge to my bank checking account checks drawn by and payable to the order of Sterling Investors Life Insurance Company, Rome, Georgia, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of Sterling Investors Life Insurance Company to sign such checks. I agree that your rights in respect to reach such check shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check. I further agree that if any such check be dishonored, whether 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.

Depositor Name: \_\_\_\_\_ Date: \_\_\_\_\_

Branch/Bank Name: \_\_\_\_\_

Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Address/City/State/Zip: \_\_\_\_\_

TO: The Bank named in the above area:

In consideration of your participating in a plan by which amounts payable to Sterling Investors Life Insurance Company are collected by checks drawn by and payable to the order of Sterling Investors Life Insurance Company on the accounts of persons who are responsible for these payments, Sterling Investors Life Insurance Company does hereby agree that:

1. It will indemnify and hold you harmless from any liability to any person having an account with you rising out of the payment by you of any check drawn by Sterling Investors Life Insurance Company on the account of such person, or arising out of the dishonor by you, whether with or without cause or intentionally or inadvertently, of any such check so drawn whether or not such claim or liability asserted against you be based upon the forfeiture, or alleged forfeiture, of a policy of insurance the premium on which is sought to be collected by Sterling Investors Life Insurance Company by any such check; and
2. It will refund to you any amount erroneously paid by you on any such check if claim for the amount of such erroneous payment is made by you within twelve months from the date of the check on which such erroneous payment was made.

**STERLING INVESTORS LIFE INSURANCE COMPANY**  
**ROME, GEORGIA**

Signature \_\_\_\_\_

Date \_\_\_\_\_