Medicare Select Application

Underwritten and administered by MercyCare HMO, Inc

PO Box 550 Janesville 53547-0550
(800) 895-2421 • mercycarehealthplans.com

MercyCare Health Plans™

Applicant Information

Name (Last, First, Middle Initial):

Date of Birth: _____/_____/_____ Gender: ❑ M ❑ F ❑ Other

Social Security Number: _____ - _____ - _____

Street Address: Apt #:

City: State: Zip: County:

Do you live at this address year-round? ❑ Yes ❑ No If no, please explain:

Phone Number: Alternate Phone Number:

Email Address:

Primary Care Physician:

How did you hear about MercyCare?

Plan Selection

Effective Date: _____/_____/_____

Select the policy you are applying for:

❑ MercyCare Medicare Select (Part B Deductible Not Covered)

❑ MercyCare Senior Supplement (Part B Deductible Covered)*

*Note: Only applicants eligible for Medicare prior to January 1, 2020, may purchase this policy.

Medicare Information

Please take out your red, white and blue Medicare card to complete this section. Fill out the information as it appears on your Medicare card.

OR

Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board.

Name (as it appears on your Medicare card):

_____

Medicare Number:_____

Is entitled to: Effective Date:

Hospital (Part A):_____

Medical (Part B):_____

You must have Medicare Parts A and B.

Other Insurance 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 our plan. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS BELOW. Please mark "Yes" or "No" below with an "X."

To the best of your knowledge:

1. Did you turn age 65 in the last six months? ❑ Yes ❑ No
   a. Did you enroll in Medicare Part B in the last six months? ❑ Yes ❑ No
   b. If yes, what is the 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 this question. If you answered "Yes" to this question –
   a. Will Medicaid pay your premiums for this Medicare Select policy? ❑ Yes ❑ No
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ Yes ❑ No

3. If 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 preferred provider plan), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START: _____/_____/_____ END: _____/_____/_____

   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Select policy? ❑ Yes ❑ No
   b. Was this your first time in this type of Medicare plan? ❑ Yes ❑ No
   c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❑ Yes ❑ No

4. Do you have another Medicare Supplement policy in force? ❑ Yes ❑ No
   a. If so, with what company, and what plan do you have?_____
   b. If so, do you intend to replace your current Medicare Supplement policy with this policy? ❑ Yes ❑ No

5. Have you had coverage under other health insurance within the past 63 days (for example, an employer, union or individual plan)? ❑ Yes ❑ No
   a. If so, with what company and what kind of policy?_____
   b. What are your dates of coverage under the other policy?
   (If you are still covered under the other policy, leave END blank.)

   START: _____/_____/_____ END: _____/_____/_____

6. Are you currently covered by another MercyCare Health Plans policy? ❑ Yes ❑ No
   a. If yes, please provide your MercyCare Member Number: _____

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Health Information Questionnaire

NOTE: Do not complete this section if you are eligible for guaranteed issue due to losing other coverage, if you are applying within six months of enrolling in Medicare Part B, or within six months of turning 65 if you were already enrolled in Medicare before turning 65.

PLEASE ANSWER ALL QUESTIONS BELOW. If you answer "Yes" to any, you are not eligible for coverage.

1. Are you currently bedridden, confined to a wheelchair or in hospice? ❑ Yes ❑ No

2. In the last year, have you been hospitalized, in a nursing facility or used Medicare-approved home health more than once? ❑ Yes ❑ No

3. Have you been diagnosed or treated for the following within the past two years?
   a. Diabetes with the need for insulin? ❑ Yes ❑ No
   b. Emphysema, Chronic Obstructive Pulmonary Disease (COPD), cystic fibrosis or the need for supplemental oxygen? ❑ Yes ❑ No
   c. Heart attack, coronary artery disease, carotid artery disease, congestive heart failure (CHF), heart rhythm disorder or heart valve disorder? ❑ Yes ❑ No
   d. Stroke, aneurysm, or peripheral vascular disease? ❑ Yes ❑ No
   e. Cancer, Hodgkin's disease, leukemia or melanoma? ❑ Yes ❑ No
   f. Cerebral palsy, Huntington's disease, multiple sclerosis, muscular dystrophy, lupus, Lou Gehrig's disease or Parkinson's disease? ❑ Yes ❑ No
   g. End Stage Renal Disease (ESRD), kidney disease or the need for dialysis? ❑ Yes ❑ No
   h. Alzheimer's disease, organic brain syndrome or senility? ❑ Yes ❑ No
   i. Mental or nervous disorders, or other major depressive disorders? ❑ Yes ❑ No
   j. Alcoholism, drug addiction or cirrhosis of the liver? ❑ Yes ❑ No
   k. Rheumatoid arthritis, broken bones due to osteoporosis, or hip or vertebral fractures? ❑ Yes ❑ No
   l. Amputation caused by disease or any paralytic conditions? ❑ Yes ❑ No
   m. Hepatitis or Acquired Immune Deficiency Syndrome (AIDS)? (You do not need to report results of an AIDS test conducted at an anonymous counseling and testing site or home test kits.) ❑ Yes ❑ No

4. Have you had any organ transplant, other than a cornea transplant, or have you been told you may need a transplant in the future due to a chronic condition? ❑ Yes ❑ No

5. At this time, due to a mental or physical disability or incapacity, do you have a person or institution authorized to legal act on your behalf and conduct your daily personal business transactions? ❑ Yes ❑ No

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Payment and Effective Date Information

At least two months premium must be sent with your application. Premium paid $ _____
Your premium will then be billed to you monthly. You may pre-pay up to twelve (12) months in advance.

You may also have the premium automatically withdrawn from either your savings account or your checking account. The payment would be withdrawn from your account on the tenth day of each month. If you choose to participate in the automatic withdrawal program (ACH Debits) you will not receive monthly statements from MercyCare. However, you will still receive at least 30 days notice of any increase in premiums.

Please check the mode of payment you prefer:
❑ Monthly Bill ❑ ACH Debits/Automatic Withdrawal

If you checked the box for ACH Debits/Automatic Withdrawal please fill out the Authorization Agreement for Direct Payments (ACH Debits) on page 3. Payments are taken out approximately the tenth of every month.

Authorization Agreement for Direct Payment (ACH Debits)

I/we hereby authorize MercyCare HMO, Inc. to initiate debit entries to my/our:
Select one: ❑ Checking Account ❑ Savings Account

Indicated at the depository financial institution named below, hereafter-called DEPOSITORY, and to debit the same to such account. I (we) aclmowledge that the origination of ACH transactions to my (our) account must comply with the provisions of US law.

Additionally, I (we) hereby authorize MercyCare HMO, Inc. to initiate credit entries to my (our) account and the DEPOSITORY to credit the same to such account, in the case where the incorrect amount has been debited to such account in error.

Depository Name: Branch:

City: State: Zip:

Routing Number:** Account Number:**

This authorization is to remain in full force and effect until MercyCare HMO, Inc. has received written notification from me (or either of us) of its termination in such time and in such manner as to afford MercyCare HMO, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Name(s) (Please Print):

MercyCare Account Number(s): 00000

Signature: Date:

**Please be sure to include a voided check from the account listed above.
A $20.00 service fee will be assessed in the event of non-sufficient funds.

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MercyCare™

Terms and Conditions

1. You do not need more than one Medicare supplement, Medicare cost or Medicare select policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement, Medicare cost or Medicare Select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement, Medicare cost or Medicare select policy can be suspended, if requested, during your entitlement to benefits under Medicaid for up to 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, Medicare cost or Medicare select policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medicaid eligibility.
5. If you are eligible for and have enrolled in a Medicare supplement or Medicare cost 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 or Medicare cost 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 or Medicare cost policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement or Medicare cost policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing your employer or union-based group health plan.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement or Medicare cost 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). See the booklet "Wisconsin Guide to Health Insurance for People with Medicare" which you received at the time you were solicited to purchase this policy.

Signature and Consent to Release Medical Information

By signing this application below, I understand and agree that:

1. All statements and answers I have given are complete and true to the best of my knowledge and belief. I understand that any material misstatement in this health questionnaire may result in the denial of claims and / or rescission of coverage.

2. The insurance I hereby apply for will be effective only when MercyCare Health Plans approves this application. Evidence of such approval will be issuance of the policy. The effective date will be the date shown on the ID card issued.

3. I hereby acknowledge that I have received a copy of the Outline of Coverage for MercyCare Medicare Select Policy and a copy of the brochure published by the Wisconsin Office of the Commissioner of Insurance entitled "Wisconsin Guide to Health Insurance for People with Medicare" on the date stated below.

4. I understand that information in this application will be used by MercyCare HMO, Inc. to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the MercyCare HMO, Inc. Medicare Supplement Policy if issued by MercyCare HMO, Inc. to me. I agree that MercyCare HMO, Inc. may release said information to its representative(s) or other person(s) performing business or legal services in connection with my claim(s) or as may be otherwise permitted by law or as I may further authorize from time to time.

5. I understand that I may request and receive a copy of this authorization. I understand that this authorization is revocable upon advance written notice given to MercyCare HMO, Inc. at its own office in Janesville, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and MercyCare HMO, Inc., its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand that this authorization will remain valid for two years from the date I, or my legal representative, execute this authorization. I further understand that a photographic copy of this authorization is as valid as the original.

6. I understand that no insurance agent or broker can modify, waive or change in any way this application; any requirement imposed by MercyCare HMO, Inc. nor bind any coverage or guarantee approval of this application. I further understand and agree that MercyCare HMO, Inc., its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorney's fees), I suffer as a result of any improper advice, action or omission on the part of any health care provider.

Signature and Consent to Release Medical Information *continued*

7. I HEREBY AUTHORIZE the Centers for Medicare & Medicaid Services to furnish information to MercyCare HMO, Inc. affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for Replacement Medical Insurance Benefits (Part B) under title XVIII of the Social Security Act and to furnish the plan information as to Part A and Part B benefits recorded, including those based on services not furnished by or through the plan, and should any enrollment be terminated, the effective month of such termination for its use in connection with operation of this plan, I also authorize MercyCare HMO, Inc. or any other holder of medical or other information to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers any information needed to administer title XVIII of the Social Security Act.

8. I RECEIVED THE MERCYCARE SENIOR OUTLINE OF COVERAGE BEFORE COMPLETING THIS APPLICATION, AND AFTER CONSIDERING ALL FACTORS I BELIEVE THAT THE MERCYCARE HMO, INC. SENIOR POLICY SUITS MY NEEDS.

_____ _____

(Applicant's Signature) (Date)

Read and sign the following notice only if you intend to replace your current Medicare supplement policy with MercyCare Senior

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

MercyCare Senior • MercyCare Health Plans • PO Box 550 • Janesville, WI 53547-0550

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

According to your application or other information you have furnished, you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a policy to be issued by MercyCare HMO, Inc. (referred to as "MercyCare" in this notice). 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 the purchase of this Medicare supplement, Medicare cost, Medicare Select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy

STATEMENT TO APPLICANT BY MERCYCARE, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement, Medicare cost, Medicare select or Medicare Advantage policy will not duplicate your existing Medicare supplement, Medicare cost, Medicare select or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare cost, Medicare select coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

❑ Additional benefits

❑ Fewer benefits and lower premium

❑ No change in benefits, but lower premium

❑ Not Applicable

❑ My plan has prescription drug coverage and I am enrolling in Medicare Part D.

❑ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment:

_____

_____

❑ Other (please specify)

_____

_____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting condition waiting periods. The insurer will waive any time periods applicable to preexisting conditions waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.
3. 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 requested material medical information on the 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 requested information has been properly reported. (If the policy is guaranteed issue, this paragraph need not appear.)

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____

(MercyCare Representative's Signature) (Date)

_____ _____

(Applicant's Signature) (Date)

Applicant address:

_____

_____

MercyCare Health Plans is required by federal law to provide the following information.

If you, or someone you're helping, have questions about MercyCare Health Plans, you have the right to get help and information in your preferred language at no cost. To talk with an interpreter, call Customer Service at 800-895-2421. [TTY: 1-800-947-3529]

Español (Spanish)

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de MercyCare Health Plans, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al Customer Service 800-895-2421 [TTY: 1-800-947-3529].

Hmoob (Hmong)

Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog MercyCare Health Plans, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau Customer Service 800-895-2421 [TTY: 1-800-947-3529].

繁體中文 (Chinese)

如果您，或是您正在協助的對象，有關於 MercyCare Health Plans 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 Customer Service 800-895-2421。[TTY: 1-800-947-3529]

Polski (Polish)

Jeśli Ty lub osoba, której pomagasz ,macie pytania odnośnie MercyCare Health Plans, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku .Aby porozmawiać z tłumaczem, zadzwoń pod numer Customer Service 800-895-2421 [TTY: 1-800-947-3529]

한국어 **(Korean)**

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 MercyCare Health Plans 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 800-895-2421 로 전화하십시오. [TTY: 1-800-947-3529]

Tagalog (Tagalog – Filipino)
Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa MercyCare Health Plans, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa Customer Service 800-895-2421 [TTY: 1-800-947-3529].

العربيـــــة (Arabic)
إن كان لديك أو لدى شخص تساعده أسئلة بخصوص MercyCare Health Plans فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل بـ 800-895-2421[TTY: 1-800-947-3529]

Русский (Russian)
Если у вас или лица, которому вы помогаете, имеются вопросы по поводу MercyCare Health Plans, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону Customer Service 800-895-2421[TTY: 1-800-947-3529].

ગુજરાતી (Gujarati)
જો તમે અથવા તમે કોઇને મદદ કરી રહ્યાં તેમાંથી કોઇને MercyCare Health Plans વિશે પ્રશ્નો હોર્ મેળવવાનો દુભાષિયો વાત
તો તમને મદદ અને મ હહતી અવિક ર છે. તે ખર્ય વિન તમ રી ભ ષ ામાં પ્ર પ્ત કરી શક ર્ છે. કરિ મ ટે,આ 800-895-2421[TTY: 1-800-947-3529] પર કોલ કરો.

Tiếng Việt (Vietnamese)
Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về MercyCare Health Plans, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi Customer Service 800-895-2421.

Deutsch (German)
Falls Sie oder jemand, dem Sie helfen, Fragen zum MercyCare Health Plans haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 800-895-2421 an.

اُردُو (Urdu)
اگر اپ کسی کو مدد دے رہے ہیں اور اپ دونوں کو سوال ہے MercyCare Health Plans کے بارے میں، تو اپ دونوں کو اپنی زبان
میں مفت مدد اور معالومات حاصل کرنے کا حق ہے۔ ترجمان سے بات کرنے کے لیے، 800-895-2421 فون کریں۔

हिंदी (Hindi)
यदि आपके ,या आप द्वारा सहायता किए जा रहे किसी व्यक्ति के MercyCare Health Plans के बारे में प्रश्न हैं , तो आपके पास अपनी भाषा में मुफ्त में सहायता और सूचना प्राप्त करने का अधिकार है। किसी दुभाषिए से बात करने के लिए ,800-895-2421[TTY: 1-800-947-3529]पर कॉल करें।

Italiano (Italian)
Se tu o qualcuno che stai aiutando avete domande su MercyCare Health Plans, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 800-895-2421 [TTY: 1-800-947-3529].

Français (French)
Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de MercyCare Health Plans, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez Customer Service 800-895-2421 [TTY: 1-800-947-3529].

Non-Discrimination Statement:

MercyCare Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. MercyCare Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

MercyCare Health Plans provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). MercyCare Health Plans provides free language services to people whose primary language is not English such as: qualified interpreters and information written in other languages. If you need these services, contact the MercyCare Health Plans Customer Service at 800-895-2421 [TTY: 1-800-947-3529].
If you believe that MercyCare Health Plans has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance. If you need help filing a grievance for discrimination, our Complaint Coordinator at 608-741-3342, is available to help you. You can file a grievance in person or by mail, fax, or email:

Complaint Coordinator
PO Box 550
Janesville, WI 53547
Phone: 608-741-3342 Fax: 608-741-5238
Email: Mcare@mhemail.org

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Agent Statement

Every insurer marketing Medicare supplement insurance must (1) ensure that any comparison of policies by its agents or other producers will be fair and accurate; (2) ensure that excessive insurance is not sold or issued; and (3) inquire and otherwise make every reasonable effort to identify whether an applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance. Also, of course, tactics such as twisting, high pressure sales, and cold lead advertising are not allowed with respect to Medicare supplement insurance. Finally, no agent or insurer may knowingly prevent or dissuade or attempt to prevent or dissuade, any person from filing a complaint with the Office of the Commissioner of Insurance; cooperating in any investigation by that Office; or attending or giving testimony at any proceeding authorized by law.

To assist MercyCare HMO, Inc. ("MercyCare") in meeting its obligations in this regard, please read this Agent Statement carefully and sign below.

Statement

I have read this Agent Statement and certify that I have not engaged in any practices that would violate the restrictions stated above.

This statement accompanies the application of _____ for MercyCare Medicare Select coverage. I have not sold any other health insurance policies to this applicant, including policies that are no longer in force, except as follows (check "None" or list insurer and policy number of applicable policies):

_____ None.

_____ The following policy or policies still in force:

_____ The following policy or policies no longer in force (may be limited to policies sold in the past 5 years):

_____ _____

_____ _____

_____ _____

Agent Name (please print) Date

_____

Agent Signature

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MercyCare™