**Section 2008.100 Requirements for Application Forms and Replacement Coverage**

a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant currently has Medicare supplement, Medicare Advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing such questions and statements may be used.

1) Statements

A) You do not need more than one Medicare supplement policy.

B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

D) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after 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 reinstituted if requested within 90 days after 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 reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.

E) 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 reinstituted if requested within 90 days after 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

F) Counseling services may be available in this State to provide advice concerning your purchase of Medicare supplement 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).

2) Questions

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. Please mark Yes or No below with an "X".

|  |
| --- |
| To the best of your knowledge: |
| A) | Did you turn age 65 in the last 6 months? |
|  | Yes [ ]  No [ ]  |
| B) | Did you enroll in Medicare Part B in the last 6 months? |
|  | Yes [ ]  No [ ]  |  |  |
| C) | If yes, what is the effective date? |  |  |

D) Are you covered for medical assistance through the State Medicaid program?

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.

|  |
| --- |
|  Yes [ ]  No [ ]  |
| If yes: |
|  |
| i) | Will Medicaid pay your premiums for this Medicare supplement policy? |
|  | Yes [ ]  No [ ]  |
|  |  |
| ii) | Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? |
|  | Yes [ ]  No [ ]  |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| START |  / / |  | END |  / / |

i) 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 [ ]  |

ii) Was this your first time in this type of Medicare plan?

|  |  |
| --- | --- |
|  | Yes [ ]  No [ ]  |

iii) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

|  |  |
| --- | --- |
|  | Yes [ ]  No [ ]  |

F) Do you have another Medicare supplement policy in force?

|  |  |
| --- | --- |
|  | Yes [ ]  No [ ]  |

i) If so, with what company, and what plan do you have (optional for Direct Mailers)?

|  |  |
| --- | --- |
|  |  |

ii) If so, do you intend to replace your current Medicare supplement policy with this policy?

|  |  |
| --- | --- |
|  | Yes [ ]  No [ ]  |

G) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

|  |  |
| --- | --- |
|  | Yes [ ]  No [ ]  |

i) If so, with what company, and what kind of policy?

|  |
| --- |
|  |
|  |
|  |
|  |

ii) What are your dates of coverage under the other policy?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| START |  / / |  | END |  / / |

(If you are still covered under the other policy, leave "END" blank.)

b) Insurance producers shall list any other health insurance policies they have sold to the applicant.

1) List policies sold that are still in force.

2) List policies sold in the past 5 years that are no longer in force.

c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

d) Upon determining that a sale will involve replacement of Medicare supplement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice signed by the applicant and the insurance producer shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage in the form prescribed in Appendix R.

e) The notice required by subsection (d) for an issuer, other than a direct response issuer, shall be provided in the form prescribed in Appendix R in no less than 12-point type.

f) Subsections (1) and (2) of Appendix R (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

g) Persons aged 65-75 who have an existing Medicare supplement policy shall be eligible commencing on their birthday for an open enrollment period of 45 days to select any of the same issuer’s other Medicare supplement policies that offer benefits equal to or lesser than the person’s existing coverage. An issuer shall not deny or condition the issuance or effectiveness of coverage or discriminate in pricing based on the person’s health status, claims experience, receipt of healthcare, or medical condition, including any preexisting condition.

h) The notice of this annual open enrollment period required by Section 363(8) of the Code shall be attached with or incorporated into the application for Medicare supplement insurance. If the notice is attached separately with the application and not embedded into the application, then it must be filed in a form filing through the System for Electronic Rate and Form Filing (SERFF) for approval by the Department prior to issuance to the applicant.

(Source: Amended at 47 Ill. Reg. 5701, effective April 4, 2023)