**Section 2008.APPENDIX R Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

Insurance company's name and address

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

According to (your application) (information you have furnished) you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide 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 purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement 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 INSURANCE PRODUCER:

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

|  |  |  |  |
| --- | --- | --- | --- |
|  | Additional benefits. | | |
|  | No change in benefits, but lower premiums. | | |
|  | Fewer benefits and lower premiums. | | |
|  | My plan has outpatient prescription drug coverage and I am enrolling in Part D for disenrollment. (Optional only for Direct Mailers) | | |
|  | Disenrollment from a Medicare Advantage plan. Please explain reason. | | |
|  | Other. (Please specify) | |  |
|  | |  | |
|  | |  | |

**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.

1) Health conditions which you may presently have (preexisting 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) Section 363(7)(b) of the Illinois Insurance Code [215 ILCS 5/363(7)(b)] provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original 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 material medical information on an 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 information has been properly recorded. [If the policy or certificate 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. | |
| (Signature of Insurance Producer or Other Representative) | |
| Typed Name and Address of Issuer or Insurance Producer | |
| (Applicant's Signature) | |
| Date |  |

\* Signature not required for direct response sales.

(Source: Appendix R renumbered from Appendix M and amended at 29 Ill. Reg. 14188, effective September 8, 2005)