*Transamerica Premier Life Insurance Company*
Home Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

## Medicare Supplement

**A. Please answer all questions completely. ONLY complete the Applicant B information if a second individual is applying for coverage.**

| **APPLICANT A** | **APPLICANT B** |
|---|---|
| 1. Name (First,MI,Last) | 1. Name (First,MI,Last) |
| 2. Residence Address (Cannot be a P.O. Box) | 2. Residence Address (Cannot be a P.O. Box) |
| 3. City | 3. City |
| 4. State Zip | 4. State Zip |
| 5. Mailing Address (If different from residence address) | 5. Mailing Address (If different from residence address) |
| 6. City | 6. City |
| 7. State Zip | 7. State Zip |
| 8. Phone Number ( ) | 8. Phone Number ( ) |
| 9. Best time to call for a Personal History Interview<br>_____a.m. _____p.m. | 9. Best time to call for a Personal History Interview<br>_____a.m. _____p.m. |
| 10. Current Age Date of Birth (MM/DD/YYYY) | 10. Current Age Date of Birth (MM/DD/YYYY) |
| 11. ☐ Male U.S. State/Country of Birth<br>☐ Female | 11. ☐ Male U.S. State/Country of Birth<br>☐ Female |
| 12. Social Security Number | 12. Social Security Number |
| 13. Medicare Health Insurance Card Number | 13. Medicare Health Insurance Card Number |
| 14. Occupation | 14. Occupation |
| 15. E-mail Address | 15. E-mail Address |
| 16. Height Ft._____ In._____ Weight Lbs._____<br>(NOTE TO APPLICANT: Do not complete if you are applying during a guaranteed issue period.) | 16. Height Ft._____ In._____ Weight Lbs._____<br>(NOTE TO APPLICANT: Do not complete if you are applying during a guaranteed issue period.) |
| 17. Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No | 17. Have you used tobacco in any form in the past 12 months? ☐ Yes ☐ No |
| 18. Secondary Addressee: A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.<br>Name (First, MI, Last) | 18. Secondary Addressee: A secondary addressee may be named who will receive copies of premium notices and letters regarding possible lapse in coverage.<br>Name (First, MI, Last) |
| Address | Address |
| City, State, Zip | City, State, Zip |
| Phone Number | Phone Number |

**B. Plan Information** (to be completed by Agent)

| **APPLICANT A** | **APPLICANT B** |
|---|---|
| 1. Medicare Supplement Plan _____ | 1. Medicare Supplement Plan _____ |
| 2. Requested Effective Date | 2. Requested Effective Date |
| 3. Mail Policy To: ☐ Owner ☐ Agent | 3. Mail Policy To: ☐ Owner ☐ Agent |
| 4. To the best of your knowledge have you been declined or denied reinstatement for Medicare Supplement? ☐ Yes ☐ No If "YES," when and why? | 4. To the best of your knowledge have you been declined or denied reinstatement for Medicare Supplement? ☐ Yes ☐ No If "YES," when and why? |
| (NOTE TO APPLICANT: Do not complete if you are applying during a guaranteed issue period.) | (NOTE TO APPLICANT: Do not complete if you are applying during a guaranteed issue period.) |

**C. Premium & Payment Method (must be completed)**

| | |
|---|---|
| 1. Medicare Supplement Premium $ _____ | 1. Medicare Supplement Premium $ _____ |
| 2. Medicare Supplement One-Time Application Fee $ 25.00 | 2. Medicare Supplement One-Time Application Fee $ 25.00 |
| 3. Total Initial Premium $ _____ | 3. Total Initial Premium $ _____ |
| 4. Mode of Payment: ☐ EFT ☐ Direct Bill ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (EFT Only) | 4. Mode of Payment: ☐ EFT ☐ Direct Bill ☐ Annual ☐ Semiannual ☐ Quarterly ☐ Monthly (EFT Only) |

**D. Please answer all of the following questions.**

| | **APPLICANT A** | **APPLICANT B** |
|---|---|---|
| 1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Are you eligible for Medicare due to disability? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "YES," are you disabled due to End Stage Renal Disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| **To the Best of Your Knowledge:** | | |
| 3. Are you covered under Medicare Part A? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "YES," what is your Part A effective date? _____ (Applicant A) _____ (Applicant B) | | |
| If "NO," what is your eligibility date? _____ (Applicant A) _____ (Applicant B) | | |
| 4. Are you covered under Medicare Part B? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "YES," what is your Part B effective date? _____ (Applicant A) _____ (Applicant B) | | |
| If "NO," indicate date you plan to enroll. _____ (Applicant A) _____ (Applicant B) | | |
| 5. Are you applying during a guaranteed issue or open enrollment period? (NOTE: If the answer above is "YES," please attach proof of eligibility and DO NOT complete section F.) | ☐ Yes ☐ No | ☐ Yes ☐ No |

**E. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests 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 certificate, or that you had certain rights to buy such a policy or certificate, 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 BELOW. Please mark "YES" or "NO" with an "X" to the questions below.**

| **To the Best of Your Knowledge:** | **APPLICANT A** | **APPLICANT B** |
|---|---|---|
| 1. Did you turn age 65 in the last six months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 2. Did you enroll in Medicare Part B in the last six months? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| If "YES," indicate your effective date. _____ (Applicant A) / _____ (Applicant B) | | |
| 3. 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 | ☐ Yes ☐ No |
| If "YES," | | |
| a. Will Medicaid pay your premiums for this Medicare supplement policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. 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_____ (Applicant A) / START_____ END_____ (Applicant B) | | |
| a. 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 | ☐ Yes ☐ No |
| b. **If "YES," have you received a copy of the replacement notice?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. Reason for termination/disenrollment? _____ (Applicant A) / _____ (Applicant B) | | |
| d. Planned date of termination/disenrollment? _____ (Applicant A) / _____ (Applicant B) | | |
| e. Was this your first time in this type of Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. Did you drop a Medicare Supplement or Medicare Select policy/certificate to enroll in this Medicare plan? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g. Is your former Medicare Supplement or Medicare Select policy/certificate still available? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Do you have another Medicare Supplement or Medicare Select policy/certificate in force? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| a. If "YES," with what company, and what plan do you have? | | |

| **APPLICANT A** | **APPLICANT B** |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Plan | Plan |
| Issue Date (MM/DD/YYYY) | Issue Date (MM/DD/YYYY) |

| | APPLICANT A | APPLICANT B |
|---|---|---|
| b. If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. **If "YES," have you received a copy of the replacement notice?** | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. 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) a. If "YES," with what company and what kind of policy/certificate? (List below) | ☐ Yes ☐ No | ☐ Yes ☐ No |

| **APPLICANT A** | | **APPLICANT B** | |
|---|---|---|---|
| Name of Company | Kind of Policy/Certificate | Name of Company | Kind of Policy/Certificate |
| | | | |

b. What are your dates of coverage under the other policy/certificate? (If you are still covered under this plan, leave "END" blank.)

START_____ END_____ / START_____ END_____
Applicant A Applicant B

c. Reason for termination/disenrollment? _____ / _____
Applicant A Applicant B

d. Planned date of termination/disenrollment? _____ / _____
Applicant A Applicant B

7. Agents shall list any other health insurance policies/certificates they have sold to the Applicant.

a. List policies/certificates sold which are still in force.

| **APPLICANT A** | **APPLICANT B** |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Description of Benefits | Description of Benefits |
| Effective Date of Coverage (MM/DD/YYYY) | Effective Date of Coverage (MM/DD/YYYY) |

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

| **APPLICANT A** | **APPLICANT B** |
|---|---|
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Description of Benefits | Description of Benefits |
| Effective Date of Coverage (MM/DD/YYYY) | Effective Date of Coverage (MM/DD/YYYY) |

**F. Personal History Questions - Complete this section only if you are NOT applying during a guaranteed issue period.**

1. **Have you been prescribed or taken any prescription medications within the past 12 months? If "YES," please indicate below. If "NO," indicate "None." Agent - This is to assist in preparing the Applicant to answer questions in sections 3 through 6.**

| **APPLICANT A**<br>**Name of Medication, Date Prescribed and Condition**<br>***(Example: Vytorin, 10/2009, High Cholesterol)*** | **APPLICANT B**<br>**Name of Medication, Date Prescribed and Condition**<br>***(Example: Vytorin, 10/2009, High Cholesterol)*** |
|---|---|
| | |
| | |
| | |
| | |

| | **APPLICANT A** | **APPLICANT B** |
|---|---|---|
| 2. To the best of your knowledge have you ever been diagnosed with diabetes by a licensed member of the medical profession? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 3. Have you ever: | | |
| a. been advised by a licensed member of the medical profession to have or are you currently waiting for an organ transplant? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. been diagnosed with, treated, or advised by a licensed member of the medical profession to receive treatment for Alzheimer's Disease, dementia, mental incapacity, organic brain disease or any other cognitive disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. been diagnosed with, treated or advised by a licensed member of the medical profession to receive treatment for Lou Gehrig's disease (ALS),Huntington's disease or any terminal medical condition? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. been diagnosed with, treated or advised by a licensed member of the medical profession to receive treatment for Systemic Lupus, Osteoporosis with Fractures, or kidney disease or failure requiring dialysis? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| e. used insulin to treat or control diabetes? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. been diagnosed with or treated by a licensed member of the medical profession for any type of Diabetes with Complications including retinopathy, neuropathy, nephropathy, peripheral vascular disease, heart disease, stroke, transient ischemic attack (TIA), high blood pressure, or skin ulcers? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| g. been diagnosed with or treated by a licensed member of the medical profession for a diabetic coma, or been advised by a licensed member of the medical profession to have an amputation due to disease or disorder? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h. been diagnosed with, treated or advised by a licensed member of the medical profession to receive treatment for Cirrhosis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| i. been diagnosed, treated or advised by a licensed member of the medical profession to receive treatment for any neurological disease or disorder such as Myasthenia Gravis, Multiple or Lateral Sclerosis, or Parkinson's disease? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 4. Tested positive for exposure to the HIV infection or been diagnosed by a licensed member of the medical profession as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 5. Within the past 2 years have you: | | |
| a. been advised by a licensed member of the medical profession to or do you currently use a wheelchair? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| b. been advised by a licensed member of the medical profession to enter or do you reside in a nursing home, assisted living facility, long term care facility, received hospice, attended an adult day care facility, required home health care, or been bedridden? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| c. been admitted to a hospital 3 or more times or are you currently admitted to a hospital? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| d. been diagnosed, treated or advised by a licensed member of the medical profession to receive treatment for cancer (other than basal cell carcinoma)? | ☐ Yes ☐ No | ☐ Yes ☐ No |

| | APPLICANT A | APPLICANT B |
|---|---|---|
| e. been diagnosed, treated or advised by a licensed member of the medical profession to receive treatment for alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| f. been diagnosed, treated or advised by a licensed member of the medical profession to receive treatment for heart attack, 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 | ☐ Yes ☐ No |
| g. been diagnosed, treated or advised by a licensed member of the medical profession to receive treatment for degenerative bone disease impacting multiple joints, crippling/disabling or rheumatoid arthritis or been advised to have a joint replacement? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| h. been advised by a licensed member of the medical profession to have surgery, medical tests, treatment or therapy that has not yet been performed or undergone testing by a medical professional for which the results have not yet been received? | ☐ Yes ☐ No | ☐ Yes ☐ No |
| 6. Have you been advised by a licensed member of the medical profession that surgery may be required within the next 12 months for cataracts or have you used or been advised to use oxygen equipment, respirator or a catheter? | ☐ Yes ☐ No | ☐ Yes ☐ No |

**If any question in 3, 4, 5 and 6 is answered "YES," please STOP. The Applicant is NOT eligible for underwritten Medicare Supplement.**

## G. Billing Information

**I would like my monthly direct payment to come from my account below (check one) on the ____ day of the month (1st-28th):** ☐ Checking **Please attach a voided check**

☐ Savings **Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.**

| Financial Institution Name: | Phone Number: |
|---|---|
| Financial Institution Address: | |
| Transit Routing Number: | Account Number: |

I hereby request and authorize Transamerica Premier Life Insurance Company to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after that first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Transamerica Premier Life Insurance Company or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Transamerica Premier Life Insurance Company's rights in respect to each charge shall be the same as if it were a check made payable to Transamerica Premier Life Insurance Company and personally signed by me. If any charge is dishonored for any reason, Transamerica Premier Life Insurance Company shall not be under any liability even though such dishonor results in the forfeiture of insurance.

_____ _____

Signature as it appears on financial institution records | Print name of account owner (if other than Applicant)

_____

Date

**If the EFT premium payment method is chosen, please tape a voided check in this box.**
**NO 3rd PARTY CHECKS PLEASE**

**H. Please Read and Sign Below**

## 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 policy.
- 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 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 reinstituted if requested with 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your 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).

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgement will be valid for 24 months after it is signed. I acknowledge and agree that this application and any amendments shall be the basis for any insurance issued and that the agent does not have the authority to waive any question on this application.

If I am applying for a Medicare supplement insurance policy, I represent that my answers and statements on this application are true and complete. I understand that, (a)upon acceptance of the completed application, each Applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Transamerica Premier Life Insurance Company.

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

Dated at _____, on_____ , _____ _____
City State Month Day Year Applicant A's Signature

Dated at _____, on_____ , _____ _____
City State Month Day Year Applicant B's Signature (if applying)

**Premium Must Accompany Application**

I/We certify that during an interview with the proposed Applicant, I/we have truly and accurately recorded in the application the information supplied by the Applicant.

_____ John Gridley
(Signature of Licensed Agent) (Print Agent Name)

1222637
Agent Number / (Stamp)

*Transamerica Premier Life Insurance Company*
Administrative Office: 4333 Edgewood Road NE, Cedar Rapids, IA 52499

# Supplemental Information for Life or Health Insurance

Proposed Primary Insured Name:_____ Social Security Number: _____

| ADDITIONAL INFORMATION | | |
|---|---|---|
| Question Number | Name of Proposed Insured | Details to General and Medical Questions (Diagnosis, Dates, Durations, and Medications, Dosages, Frequency) Medical Facilities & Physicians Names, Addresses, Phone Numbers |
| | | |

**ADDITIONAL INFORMATION**

Dated at_____ this _____ day of _____ , _____
City State Month Year

_____ _____
Signature of Proposed Insured Signature of Proposed Owner (if other than Proposed Insured)

_____ _____
Signature of Parent or Legal Guardian (if Proposed Insured is Under 18 years of age) Signature of Additional Insured

_____
Signature of Agent/Registered Rep/Witness/Vendor Rep

## CONDITIONAL RECEIPT

No coverage will be effective prior to delivery of the policy applied for unless and until all the following conditions are met:

**Conditions of Coverage**

1. On the Effective date indicated below, the state of health and all factors affecting insurability of each person proposed for coverage must be stated in the application required by the Company and the application must not contain a material misrepresentation;

2. An amount equal to the first full premium required is paid during the lifetime of all persons proposed for coverage and any check, money order, or Authorization for Electronic Funds Transfer (EFT) given in payment is honored when first presented; and,

3. For Life Insurance – Each person proposed for coverage is on the Effective Date insurable and acceptable to the Company under all applicable Company underwriting standards for the plan and for the amount applied for, without modification of plan, premium of rates, or amount of coverage; or

For Medicare Supplement Insurance – The person applying for coverage has had his/her application accepted by the Company under its underwriting standards and applicable Company rules for the Medicare Supplement Plan applied for.

**Effective Date**

For Life Insurance – If all of the above conditions are met, insurance in the amount applied for or $25,000, whichever is lower, will become effective on the date the application is completed. If any of the above conditions are not met, or if the proposed insured dies by suicide, this receipt provides no coverage, and the liability of the Company is the return of the amount remitted with this receipt. Coverage which takes effect through this receipt will terminate at the EARLIEST of the following: (a) the effective date of the policy; (b) thirty (30) days after the date of the application; (c) three (3) days after the date the Company sends written notice that the receipt is terminated.

For Medicare Supplement Insurance – If all of the applicable conditions here are met, the Medicare Supplement Plan applied for will become effective on the date stated on the Policy Schedule Page. If any of these conditions are not met, coverage will not take effect and the liability of the Company is the return of any amount paid by the applicant.

## MIB DISCLOSURE NOTIFICATION

Information regarding your insurability will be treated as confidential. Transamerica Premier Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

Transamerica Premier Life Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

# OPEN ENROLLMENT AND GUARANTEED ISSUE WORKSHEET

**If <u>any</u> of the following situations apply, applicant is in an open enrollment or guaranteed issue period:**
(Situations may vary by state and coverage may be limited. Please refer to the Underwriting Guide for more information.)

## ELIGIBILITY FOR OPEN ENROLLMENT

**Applicant is:**

- at least 64½ years of age (in most states) and within six months before or after his/her effective date for Medicare Part B, or
- covered under Medicare Part B prior to age 65 (eligible for a six-month open enrollment period upon reaching age 65)

**Note: Coverage cannot be effective until your Medicare coverage is effective.**

## ELIGIBILITY FOR GUARANTEED ISSUE

**Evidence of eligibility is required for the following situations.**
**Applicant:**

- is in the original Medicare plan, has an employer group health plan (including retiree or COBRA coverage) or union coverage that pays after Medicare pays, and that coverage is ending
- is in the original Medicare plan, has a Medicare Select policy, and moves out of the Select plan's service area
- loses coverage due to their Medicare supplement insurance company's insolvency or at no fault of the applicant
- the applicant leaves their Medicare supplement plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

**Applicant was enrolled in a Medicare Advantage (MA) plan, and:**

- the plan is leaving the Medicare program or stops service in the applicant's area, or the applicant moves out of the plan's service area (applicant must switch back to original Medicare)
- the applicant leaves the plan because the company has not followed rules, or has misled the applicant

*Applicant has the right to buy Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

- the applicant decided to switch to original Medicare within the first year of joining a MA plan when first eligible for Medicare Part A at age 65

*Applicant has the right to buy Medicare supplement plan that is sold in the applicant's state by any insurance company.*

- after dropping their Medicare supplement policy to join a MA plan for the first time, has been on the MA plan less than one year and wants to switch back

*Applicant has the right to buy Medicare supplement policy back if that carrier still sells it or, if not available, buy any Medicare supplement Plan A, B, C, F, K or L that is sold in the applicant's state by any insurance company.*

## Acceptable Evidence of Eligibility:

a. Copy of the applicant's MA plan's termination notice
b. Copy of the letter the applicant sent to his/her MA plan requesting disenrollment
c. Signed statement that the applicant has requested to be disenrolled from his/her MA plan
d. Certification of group coverage
e. Copy of the termination letter from employer or group carrier
f. Image of insurance ID card (<u>ONLY</u> allowed if your MA plan is being terminated)

**Transamerica Premier Life Insurance Company**
4333 Edgewood Road NE, Cedar Rapids, IA 52499

# HIPAA Authorization for Release of Health-Related Information

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

| Name of Primary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
|---|---|---|
| Name of Secondary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
| Name(s) of Unemancipated Minors | Date(s) of birth | Last four digits of SSN(s) |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

## STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

**A copy of this authorization will be considered as valid as the original.**

**Transamerica Premier Life Insurance Company**
4333 Edgewood Road NE, Cedar Rapids, IA 52499

# HIPAA Authorization for Release of Health-Related Information

**This authorization complies with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.**

| Name of Primary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
|---|---|---|
| Name of Secondary Proposed Insured/Patient | Date of birth | Last four digits of SSN |
| Name(s) of Unemancipated Minors | Date(s) of birth | Last four digits of SSN(s) |

I hereby authorize the use or disclosure of health information, as described below, about me or my above-named unemancipated minor children and revoke any previous restrictions concerning access to such information:

1. **Person(s) or group(s) of persons authorized to use and/or disclose the information:** Any health plan, physician, health care professional, hospital, clinic, long-term care facility, medical or medically-related facility, laboratory, pharmacy, pharmacy benefit manager, insurance company [including the Companies noted above (the "Companies")], insurance support organization such as MIB Group, Inc., or other medical practitioner or health care provider that has provided payment, treatment or services to me or on my behalf or to or on behalf of my unemancipated minor children.
2. **Person(s) or group(s) of persons authorized to collect or otherwise receive and use the information:** The Companies, their affiliates and reinsurers, and their agents, employees, or other representatives. I further authorize the Companies and their affiliates and reinsurers to redisclose the information to MIB Group, Inc., which operates an information exchange on behalf of life and health insurance companies.
3. **Description of the information that may be used or disclosed:** This authorization specifically includes the release of all information related to my health or that of my unemancipated minor children and my or my unemancipated minor children's insurance policies and claims, including, but not limited to, information on the diagnoses, prognoses, treatments, prescription drug information, and information regarding diagnosis, prognosis and treatment of mental illness, communicable or infectious conditions, such as HIV or AIDS, and use of alcohol, drugs and tobacco. **This Authorization excludes psychotherapy notes that are separated from the rest of my medical records.**
4. **The information will be used or disclosed only for the following purpose(s):** For the purpose of underwriting my insurance application with the Companies, to support the operations of our business, and, if a policy is issued, for evaluating contestability and eligibility for benefits, for the continuation or replacement of the policy, for reinstatement of the policy or to contest a claim under the policy.

## STATEMENTS OF UNDERSTANDING & ACKNOWLEDGMENT:

- I understand that health information about me provided to the Companies may be protected by state and federal privacy regulations including the HIPAA Privacy Rule and that the Companies will only use and disclose such information as permitted by applicable regulations and as described in their privacy notices. However, I also understand that any information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations such as the HIPAA Privacy Rule governing privacy and confidentiality of health information.
- I understand that if I refuse to sign this authorization to release my health information or that of my unemancipated minor children, the Companies may not be able to process my application, or if coverage is issued may not be able to make any benefit payments.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it, or to the extent that other law provides the Companies with the right to contest a claim under the policy or the policy itself, by sending a written revocation to the Companies' Privacy Official at the address at the top of this form. I also understand that the revocation of this authorization will not affect uses and disclosures of my health information for purposes of treatment, payment and business operations, including agent commission statements.
- This authorization shall remain in force for 24 months (12 months in Kansas) from the date signed, regardless of my condition and whether living or deceased.
- I acknowledge I have received a copy of this authorization.

_____ _____
Signature of Primary Proposed Insured/Patient or Personal Representative — Date

_____ _____
Signature of Secondary Proposed Insured/Patient or Personal Representative — Date

**If signed by an individual's personal representative or the parent or guardian of an unemancipated minor, describe authority to sign on behalf of the individual:**

❑ Parent ❑ Legal guardian ❑ Power of Attorney ❑ Other (please describe): _____

(NOTE: If more than one individual is named above, please specify the individual(s) to which the personal representative applies.)

Policy or contract number (if known): _____

**A copy of this authorization will be considered as valid as the original.**

**Notice To Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

**Transamerica Premier Life Insurance Company**
Home Office: Cedar Rapids, IA 52499
Administrative Office: 4333 Edgewood Rd. NE, Cedar Rapids, Iowa 52499

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with the enclosed Medicare Supplement coverage issued by Transamerica Premier Life Insurance Company. 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 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 Issuer - Agent, Broker or other Representative:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) *(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.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment _____
- ☐ Other (*please specify*)_____

1. Health conditions which you may presently have may not be immediately or fully covered under the new Medicare Supplement coverage. 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 coverage.

2. State law provides that your replacement coverage may not contain new waiting periods, elimination periods or probationary periods. We will waive any time periods applicable to waiting periods, elimination periods or probationary periods in your new coverage for similar benefits to the extent such time was spent under your original coverage.

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, if any. 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.

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

_____

(Signature of Agent, Broker or Other Representative)

_____

(Applicant's Signature)

_____

(Date)

**Notice To Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

**Transamerica Premier Life Insurance Company**
Home Office: Cedar Rapids, IA 52499
Administrative Office: 4333 Edgewood Rd. NE, Cedar Rapids, Iowa 52499

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

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with the enclosed Medicare Supplement coverage issued by Transamerica Premier Life Insurance Company. 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 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 Issuer - Agent, Broker or other Representative:**

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) *(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.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment _____
- ☐ Other (*please specify*)_____

1. Health conditions which you may presently have may not be immediately or fully covered under the new Medicare Supplement coverage. 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 coverage.

2. State law provides that your replacement coverage may not contain new waiting periods, elimination periods or probationary periods. We will waive any time periods applicable to waiting periods, elimination periods or probationary periods in your new coverage for similar benefits to the extent such time was spent under your original coverage.

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, if any. 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.

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

_____

(Signature of Agent, Broker or Other Representative)

_____

(Applicant's Signature)

_____

(Date)

# Transamerica Premier Life Insurance Company

Home Office: 4333 Edgewood Road NE, Cedar Rapids, Iowa 52499

## AGENT CERTIFICATION

I the undersigned insurance agent certify;

**THAT,** I have taken an application for:

**Primary Insured:**
Medicare Supplement Standard
- ❑ Plan A
- ❑ Plan F
- ❑ Plan G
- ❑ Plan N
- ❑ Other _____

**Applicant B:**
Medicare Supplement Standard
- ❑ Plan A
- ❑ Plan F
- ❑ Plan G
- ❑ Plan N
- ❑ Other _____

Offered by **Transamerica Premier Life Insurance Company,**

to _____
(Applicant(s)),

**THAT,** I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

**THAT,** I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

$ _____ which has been paid to me by ❑ Check ❑ EFT (Check appropriate method of payment)

**THAT,** I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

**THAT,** I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

_____
Date

_____
Signature of Agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

_____
Agent Number / Office ID

_____
Signature of Applicant

_____
Address of Agent

_____
Signature of Spouse, if Applying

_____
Agent Phone Number

AGTCERT 0714

**RETURN TO COMPANY**

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

# EXPRESS ISSUE COVER SHEET

(Please submit completed sheet with every application)

| **Agent Information** | | |
|---|---|---|
| Agent Name (Print) | Agent Email | Agent Phone<br>( ) |
| Agent ID | Office ID | Agent Fax<br>( ) |

| **Proposed Insured(s) Information** | |
|---|---|
| Insured's name(s) (Print) | Last 4 digits of Insured's social security # |

Required Forms with Application:

- ❑ HIPAA Authorization Form

Other Disclosures (if applicable):

- ❑ Accelerated Death Benefit Disclosure Form (Final Expense Sale Only)
- ❑ Replacement Form(s)
- ❑ Other State Disclosures
- ❑ Agent Certification (Medicare Supplement Sale Only)

How are you paying the Initial Premium?

- ❑ By Check: Available with all methods, but must be used if subsequent payments are quarterly, semi-annual or annual
- ❑ Draft initial premium and applicable app fees upon receipt

**We will draft the initial premium plus any applicable app fees upon receipt of the application. Future payments will be taken on the specified date found in the Billing Information Section of the Application.**

**Submitting Application to Transamerica Premier:** ***(Faxing is the preferred method)***

If faxing, fax to 1-866-834-0437 and enter date faxed _____ . **Do not mail originals if faxing.**

If mailing the application and/or check for initial premium please send with cover sheet to:

**Transamerica Premier Life, 4333 Edgewood Road NE, Cedar Rapids, IA 52499**



RETURN TO COMPANY

# THANK YOU FOR APPLYING FOR A TRANSAMERICA PREMIER MEDICARE SUPPLEMENT INSURANCE PLAN

**For your records:**

| | Applicant A | Applicant B |
|---|---|---|
| • You selected Plan | _____ | _____ |
| • Based on the information you provided, your monthly premium for the plan you selected is | $_____ | $_____ |

- You will be notified when review of your application has been completed

## WHAT'S NEXT

**Once your Application is approved, you will receive:**

- Your insured member identification card(s)
- A Welcome Kit, including your certificate of insurance and coverage details
- Help and answers to any questions you may have from courteous Customer Service Representatives

TRANSAMERICA®
PREMIER LIFE INSURANCE COMPANY

# HIPAA NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Privacy Notice is provided to you in connection with your health plan from one of the following affiliated insurance companies (referred to as "we', "our" or "us"):

Stonebridge Life Insurance Company
Transamerica Financial Life Insurance Company
Transamerica Life Insurance Company
Transamerica Premier Life Insurance Company

**This notice is effective September 23, 2013 and applies to certain Health Plans such as : Dental, Extended Hospital Expense Rider, Limited Benefit Medical Expense (Retiree Medical), Long Term Care, Medicare Supplement, Prescription Drug Coverage, Student Health, Supplemental Medical Expense and TRICARE.**

## Our Commitment to Your Privacy

We are committed to maintaining the privacy of your protected health information. This notice will tell you about the ways in which we may use and disclose your protected health information for payment, health care operations, and other circumstances as either required or permitted by law. **Except as outlined below, we will not use or disclose your protected health information without your written authorization, which you may revoke as described in the "Your Privacy Rights" section below.** For example, use or disclosure of your protected health information for marketing, or any disclosure that would constitute a sale of your protected health information, would require your authorization.

We are required by law to: safeguard your protected health information; give you this notice of our duties and privacy practices; notify you in the event of a breach of your unsecured protected health information; and abide by the terms of the Notice of Privacy Practices currently in effect. **The laws of your state may provide additional privacy rights.**

We reserve the right to change any of our privacy practices and the terms of this notice, and to make the new notice effective for all protected health information maintained by us. In the event of a material change, a revised notice will be sent to all of our policyholders.

## USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

1. **Treatment.** We do not make treatment decisions, but we may disclose your information to those who do. For example, we may disclose information regarding your benefits to doctors, hospitals, long term care facilities, and other health care providers involved in your care.

2. **Payment**. We may use and disclose your protected health information as necessary for benefit verification and claims processing purposes. For instance, we may use information regarding health care services you receive from service providers such as physicians, hospitals, pharmacies, nursing homes, assisted living facilities, and home health care agencies to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health plan. We may also forward such information to another health plan, which may also have an obligation to process and pay claims on your behalf. Examples of our payment related purposes also include our collection of premiums, coordinating reinsurance, and care coordination activities.

3. **Health Care Operations.** We will use and disclose your protected health information as necessary, and as permitted by law to operate our business including performing quality improvement and assurance, conducting cost-management and business planning, enrollment, underwriting, reinsurance, compliance, auditing, rating, customer service, fraud prevention and reporting, research purposes, specialized government functions, payment of agent commissions, and other functions related to your health plan. With the exception of long-term care insurance underwriting, we are prohibited from using or disclosing your protected health information that is genetic information for underwriting purposes. If our long-term care insurance underwriting uses genetic information it will only be used in a manner allowed by law.

4. **Family and Friends Involved in Your Care.** We may disclose your protected health information to certain family, friends, and others who are involved in your care or in the payment for your care in order to not hinder that person's involvement. If you are unavailable, incapacitated, or facing an emergency medical situation, or if we have determined, based on our professional judgment and review of the circumstances, that you would not object and that a limited disclosure may be in your best interest, we may share limited protected health information without your approval. If you have designated a person to help prevent the unintentional lapse of your coverage, we will inform that person prior to terminating the policy for nonpayment of premium. We may also disclose limited protected health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures by contacting us at the address shown at the end of this notice.

5. **Business Associates**. Certain services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, claims investigation and adjudication, underwriting support services, care coordination services, etc. We may disclose your protected health information to one or more of these outside persons or organizations that assist us with our health care operations. We obligate business associates to appropriately safeguard the privacy of your protected health information.

6. **Collection of Information.** To properly underwrite, rate, and administer your health plan, we may collect health and non-health personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, with your authorization, we may also collect or verify information by contacting information sources such as: insurance support organizations (like Medical Information Bureau, Inc.); insurance companies to which you have applied for coverage; and medical professionals and facilities which have provided services to you.

7. **Agents.** Your agent is our business associate. For customer service purposes, your agent may be notified of certain coverage-related matters and information necessary to assist in servicing your coverage. For example, your agent may be notified if we: decline your application, offer you coverage at a higher than standard rate, or offer to accept the application with modifications to the benefits you requested. We may also notify your agent when there is a change in premium paying status, when we receive notice of a claim, or notice of the cancellation or replacement of your policy. Your agent may be notified on their commission statement that your policy remains in force for as long as you continue to pay your premium.

8. **Plan Sponsors.** We may also use or disclose protected health information to the plan sponsor of a group health plan, if applicable, provided that any such plan sponsor certifies that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.

9. **Health-Related Benefits and Services.** We or our business associates may contact you regarding health-related benefits and services that may be of interest to you.

10. **Mergers and Acquisitions.** Your protected health information may also be disclosed as a part of a potential sale, merger or acquisition involving our business.

**USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES**

Your protected health information may be used or disclosed as applicable without your authorization in the following circumstances:

- for any purpose when required by law;
- for public health and/or law enforcement activities consistent with law if we suspect child abuse, elder abuse, or neglect or believe you to be a victim of abuse, neglect, domestic violence, or other crimes;
- as required by law for governmental oversight agency conducting audits, investigations (such as investigations in to consumer complaints), or civil or criminal proceedings;
- if required by a court or an administrative ordered subpoena or discovery request;
- as required by law for certain law enforcement purposes; about deceased persons to coroners, health examiners, and funeral directors consistent with law;
- if necessary for organ and tissue donation or transplant;
- for certain government-approved research purposes;
- upon reasonable belief to avert a serious threat to health or safety;
- for specialized government functions (such as military personnel and inmates in correctional facilities);
- for national security or intelligence activities;
- to workers' compensation agencies if necessary to make a benefit determination;
- to Non-affiliated organizations or persons, such as other insurance institutions, agents, insurance support organizations (such as Medical Information Bureau, Inc.), or law enforcement and governmental authority as necessary to prevent or investigate criminal activity, fraud, material misrepresentation or material non-disclosure in connection with your coverage or application for coverage;
- to our parent company and affiliates in conjunction with health care operation purposes.

**Your Privacy Rights**

Your rights are explained below. ***Any written requests to exercise those rights should be directed to the address provided at the end of this notice.***

1. **Restrictions.** You have the right to request restrictions on certain of our uses and disclosures of your protected health information for treatment, payment, or health care operations by notifying us in writing. Your request must describe in detail the restriction you are requesting. We will evaluate all requests; however, we are not required to agree to the restriction and we retain the right to terminate a restriction if we believe such termination is appropriate. In the event of a termination by us, you will be notified. You also have the right to terminate a restriction, in writing. You may obtain a Request for Restriction form by contacting us at the phone number listed at the end of this notice.

2. **Confidential Communications.** You may request that we send communications of health information to you by alternative means or to alternative locations, if all or part of that information could endanger you. For example, you may ask that we contact you at work, rather than at home. We will try to accommodate reasonable requests. You may obtain a Request for Confidential Communication form by contacting us at the phone number listed at the end of this notice.

3. **Access.** You have a right to access much of the protected health information that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies, postage, labor and supplies and, in certain cases, may deny your request. You may obtain a Request for Access form by contacting us at the phone number listed at the end of this notice.

4. **Amendment.** You have the right to request that protected health information we maintain about you be amended or corrected. We will give each request consideration; however we are not obligated to make requested amendments. All

amendment requests must be in writing, signed by you or your representative and state the reason(s) for the request. If an amendment or correction is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain a Request for Amendment form by contacting us at the phone number listed at the end of this notice.

5. **Accounting.** You have the right to receive an accounting of certain disclosures made by us of your protected health information within the six (6) calendar years immediately preceding such a request. Requests must be made in writing and signed by you or your representative. The first accounting in any 12-month period is free; but we may charge you for additional accountings within the same 12-month period. You will be notified in advance of any fee. You may obtain a Request for Accounting of Disclosure form by contacting us at the phone number listed at the end of this notice.

6. **Revocation of Authorization**. If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance on such authorization, or if other law provides us with the right to contest a claim under the policy or the policy itself. Note: your revocation will not prevent us from using collected information in conjunction with our fraud prevention program.

7. **Paper Copy of this Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy upon request.

**NOTE:** The rights granted to you do not extend to information about you relating to or in anticipation of a claim or civil or criminal proceeding.

**Complaints**

If you believe your privacy rights have been violated, you can file a complaint with us by sending your written complaint to our Consumer Affairs Department at the address given below. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

**Contacting Us**

To file a complaint or to make a request as described in the section entitled "Your Privacy Rights," please send your written request to the company at: 4333 Edgewood Road NE, Cedar Rapids, IA 52499. Requests should be directed to our Customer Service Department and Complaints should be sent to the attention of our Consumer Affairs Department. Please be sure to include the following information:

- Your full name
- Address
- Date of Birth
- Last four digits of your Social Security Number
- Policy number
- The nature of your request or complaint

**FOR FURTHER INFORMATION** regarding our HIPAA Notice of Health Information Privacy Practices or our general privacy practices, please write to us at the address shown above or call 1-866-512-7495.

**THIS NOTICE IS REQUIRED BY FEDERAL LAW. WE MAKE IT AVAILABLE TO THE GENERAL PUBLIC, APPLICANTS AND POLICYHOLDERS. YOUR RECEIPT OF THIS NOTICE IS NOT EVIDENCE OF COVERAGE.**

Medicare Supplement Insurance policies issued by Transamerica Premier Life Insurance Company. Policy Form Nos. MSH1A, MSH1F, MSH1G, MSH1N. This Medicare Supplement Insurance plan is not connected with or endorsed by the U.S. Government or Federal Medicare Program.



78965MS_OR 1114