**The Florida Office of Insurance Regulation (Office) developed the following worksheet to assist companies in drafting and submitting a Medicare Supplement Application for review by the Office. The Office encourages, but does not require, the company to download, complete, scan, and upload this form as part of the form filing as it will expedite the review process. The Office offers this worksheet as guidance only and it should not be considered a directive by the Office. The worksheet does not contain all of the requirements for Medicare Supplement filings, but instead incorporates guidance for point of law frequently overlooked in filings.**

# MEDICARE SUPPLEMENT APPLICATION WORKSHEET
## (Includes Replacement Notice)
## Individual and Group
## Standard and Select Plans

| Statute/Rule | FILING COMPLIANCE | Yes | No | N/A | Page # |
|---|---|---|---|---|---|
| 69O-149.021 | Required information to be submitted within the filing. | | | | |
| 69O-149.023(4) | Include a description of the distribution system (e.g., direct marketing, agents, financial institutions, etc.) and intended target population. | | | | |
| 69O-149.021(6)(c) | If not submitted already, the Office will ask for form number(s), date(s) of approval, Florida file number(s), (e.g. FLH 19-234560), and type of coverage of all policies or other related forms to be used or issued in connection with the form(s) submitted. | | | | |
| | **REPLACEMENT NOTICE & AGENT'S CERTIFICATION** | | | | |
| 69O-156.015(4) | Required notice to applicant regarding replacement of Medicare supplement insurance. | | | | |
| 69O-156.015(5) | Replacement Notice must be substantially similar to the notice contained in the Rule. | | | | |
| 69O-156.106 | Agent's Certification Form | | | | |
| | **MANDATORY STATEMENTS**<br>**(Includes Open Enrollment and Guarantee Issue)** | | | | |
| 69O-156.015(1)(a) | The application shall contain this statement: You do not need more than one Medicare Supplement policy. | | | | |
| 69O-156.015(1)(b) | The application shall contain this statement: If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. | | | | |
| 69O-156.015(1)(c) | The application shall contain this statement: You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. | | | | |

| Statute/Rule | FILING COMPLIANCE | Yes | No | N/A | Page # |
|---|---|---|---|---|---|
| | **MANDATORY STATEMENTS**<br>**(Includes Open Enrollment and Guarantee Issue)** | | | | |
| **69O-156.015(1)(d)** | **The application shall contain this statement: 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 within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.** | | | | |
| **69O-156.015(1)(e)** | **The application shall contain this statement: 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.** | | | | |
| **69O-156.015(1)(f)** | **The application shall contain this statement: 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).** | | | | |

| Statute/Rule | FILING COMPLIANCE | Yes | No | N/A | Page # |
|---|---|---|---|---|---|
| | **MANDATORY QUESTIONS (Includes Open Enrollment and Guarantee Issue)** | | | | |
| **69O-156.015(1)** | **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 our application. PLEASE ANSWER ALL QUESTIONS.** | | | | |
| **69O-156.015(1)(a)** | **The application shall contain the following question: To the best of your knowledge, did you turn age 65 in the last 6 months? Yes__ No __.** | | | | |
| **69O-156.015(1)(b)** | **Did you enroll in Medicare Part B in the last 6 months? Yes__ No__.** | | | | |
| **69O-156.015(1)(c)** | **If yes, what is the effective date?** | | | | |
| **69O-156.015(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.]** | | | | |
| **69O-156.015(2)(a)** | **If yes, Will Medicaid pay your premiums for this Medicare supplement policy? Yes__ No __.** | | | | |
| **69O-156.015(2)(b)** | **Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes__ No __ .** | | | | |
| **69O-156.015(3)(a)** | **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 /__/_** | | | | |
| **69O-156.015(3)(b)** | **If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes __ No __.** | | | | |
| **69O-156.015(3)(c)** | **Was this your first time in this type of Medicare plan? Yes__ No __.** | | | | |
| **69O-156.015(3)(d)** | **Did you drop a Medicare supplement plan to enroll in the Medicare plan? Yes__ No __** | | | | |

| Statute/Rule | FILING COMPLIANCE | Yes | No | N/A | Page # |
|---|---|---|---|---|---|
| | **MANDATORY QUESTIONS (Includes Open Enrollment and Guarantee Issue)** | | | | |
| **69O-156.015(4)(a)** | **Do you have another Medicare supplement policy in force? Yes__ No ___.** | | | | |
| **69O-156.015(4)(b)** | **If so, with what company, and what plan do you have [optional for Direct Mailers]?** | | | | |
| **69O-156.015(4)(c)** | **If so, do you intend to replace your current Medicare supplement policy with this policy? Yes__ No ___.** | | | | |
| **69O-156.015(5)** | **Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan) Yes___ No___.** | | | | |
| **69O-156.015(5)(a)** | **If so, with what company and what kind of policy?** | | | | |
| **69O-156.015(5)(b)** | **What are your dates of coverage under the other policy? START __ /__/_ END __ /__/__ (If you are still covered under the other policy, leave "END" blank.)** | | | | |
| **69O-156.015(2)** | **Application shall have a place available for the agent to list any other health insurance policies they have issued to the applicant.** | | | | |
| **69O-156.015(2)(a)** | **Application shall have a place available to list policies which are still in force.** | | | | |
| **69O-156.015(2)(b)** | **Application shall have a place available to list policies issued in the past five (5) years which are no longer in force** | | | | |
| **69O-156.108(3)(c)** | **If coverage is limited by pre-existing conditions, a statement must appear in the application preceding the applicant's signature.** | | | | |
| **69O-156.119** | **The application in any advertisement shall contain the name of the Florida agent.** | | | | |
| | **MEDICALLY UNDERWRITTEN ONLY** | | | | |
| **627.429(4)(e)** | **The AIDS question must be specific by inquiring whether the applicant: "has been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS, caused by the HIV infection or other sickness or condition derived from such infection."**<br>**<u>An insurer may not inquire as to whether a person has been tested for or has received a negative result from a specific test for exposure to the HIV infection or for a sickness or a medical condition derived from such infection.</u>** | | | | |

| Statute/Rule | FILING COMPLIANCE | Yes | No | N/A | Page # |
|---|---|---|---|---|---|
| | **GENERAL APPLICATION REQUIREMENTS** | | | | |
| **627.4085** | **The first page of all applications shall prominently display the name of the insuring entity.** | | | | |
| **627.4085** | **All applications must have a space for the agent's name and FL license identification number.** | | | | |
| **624.428** | **The licensee taking an application in this state must be identified as a FL 'agent'.** | | | | |
| **627.602(1)(f)**<br><br>**69O-149.021(1)(b)** | **All contracts and related forms shall contain a form number in the lower left-hand corner of the first page of the form. If the filing includes a form that is being revised since its last approval, the form number must also include a revision date.** | | | | |
| **627.639** | **Application signed by agent.** | | | | |
| **817.234(1)(b)** | **Fraud Statement: "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."** | | | | |
| | **AUTHORIZATION TO RELEASE MEDICAL INFORMATION** | | | | |
| **69O-128.018(1)(b)** | **General description of information to be disclosed.** | | | | |
| **69O-128.018(1)(c)** | **General description of parties involved with the information.** | | | | |
| **69O-128.018(1)(d)** | **Insured's signature.** | | | | |
| **69O-128.018(2)** | **Release is valid for no more than 24 months.** | | | | |
| **69O-128.018(3)** | **Insured may revoke authorization at any time.** | | | | |
| **69O-128.018(4)** | **Licensee shall retain the authorization or a copy.** | | | | |
| | **2020 MACRA Supplement Benefit Plans** | | | | |
| **69O-156.0086(1)** | **Are Plans C, F or High Deductible F offered in the form?** | | | | |
| **69O-156.0086(6)(e)** | **Is Plan G High Deductible offered to the consumer?** | | | | |
| **69O-156.0086(6)(e)** | **Has Plan G High Deductible been filed / approved?** | | | | |
| **69O-156.0086(3)** | **If a company offers any Plan in addition to Plan A, they must also offer Plan D or Plan G to Newly Eligible Beneficiaries, on or after January 1, 2020.** | | | | |
| **69O-156.0086(5)** | **Has the Outline of Coverage been revised to comply with MACRA requirements?** | | | | |

**Additional Notes:**
Please upload all documents with document titles that accurately reflect their contents including specific form numbers in the "Forms to Be Reviewed" section of the Universal Standard Data Letter (UDL).