

## MEDICARE SUPPLEMENT FILING SUMMARY

Company Name:

Contract Form Numbers:

Plans:

Pre-existing Condition Exclusion Included? Choose Yes/No

Customer Service Number:

CHECK ONE BOX IN EACH LINE

### Type

- |  |    |  |
|--|----|--|
| <input type="checkbox"/> Group Contract      | or | <input type="checkbox"/> Individual Contract |
| <input type="checkbox"/> Medicare Supplement | or | <input type="checkbox"/> Medicare Select     |

### Form

- |   |    |  |
|---|----|--|
| <input type="checkbox"/> Direct Response Marketing          | or | <input type="checkbox"/> Producer Marketed                         |
| <input type="checkbox"/> Guarantee Issue*                   | or | <input type="checkbox"/> Medically Underwritten                    |
| <input type="checkbox"/> Medicare Eligible by Reason of Age | or | <input type="checkbox"/> Medicare Eligible by Reason of Disability |

\*Choose Medically Underwritten if you only guarantee issue your plans during open enrollment and where required by law.