The EPIC Life Insurance Company®
A WPS Company

FOR USE WITH EFFECTIVE DATES OF JAN. 1, 2026, OR LATER

Please use the postage-paid envelope provided or mail completed application to:

The EPIC Life Insurance Company—Attn: Sales
1717 W. Broadway | P.O. Box 8190 | Madison, WI 53708-8190 Or fax this completed document to 1-608-223-3639

MEDICARE SUPPLEMENT PLAN ENROLLMENT APPLICATION

INSTRUCTIONS: You may not apply more than three (3) months prior to becoming eligible for coverage. Please complete all information requested on this application and mail this entire form to the address above. If application is being completed through an agency, the agent must complete and submit the agency form (section 10 of this application). You must have Medicare Parts A and B to enroll. If you have other Medicare supplement insurance that you don't intend to cancel, you are not eligible for this Medicare supplement plan.

Reason for application: ◯ Initial enrollment ◯ Re-enrollment ◯ Changing plans

1. APPLICANT INFORMATION

Last name_____ First _____ Middle _____

Date of birth_____ Sex _____

Home address _____

City _____ County _____ State _____ ZIP code _____

Mailing address (if different)_____

City _____ County _____ State _____ ZIP code _____

Telephone number (_____) _____

Email address _____

Medicare number _____

Medicare Part A effective date _____ Medicare Part B effective date _____

Is anyone who resides in your household* already enrolled in or currently applying for an EPIC Medicare supplement?
◯ Yes ◯ No

If yes, household member's full name _____

Household member's Medicare number_____

Household member's effective date of EPIC Medicare supplement policy _____

2. PLAN EFFECTIVE DATE

If EPIC approves you for coverage under this Medicare supplement policy, the policy's effective date will be the latest of:

A. The first day of the calendar month in which you become enrolled in Medicare Part B; or

B. The first day of the calendar month following the date of EPIC approval; or

C. Requested effective date _____/01/_____ (must be the first of the month)

*Household: Two or more individuals who reside together in the same dwelling. For purposes of this definition, "dwelling" means a single home, condominium unit, or apartment unit within an apartment complex.

3. PLAN SELECTION

Plans available to ALL applicants

Highest coverage available

- ☐ **Plan G** - Basic Benefits, Part A Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency, Medicare Part B Excess Charges (100%)
- ☐ **Plan N** - Basic Benefits, Part A Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency, Part B Coinsurance (100%) less a $20 copay per office visit and a $50 copayment for ER
- ☐ **Plan A** - Basic Benefits
- ☐ **Plan L** - 25% Cost-Sharing

Lowest coverage available

- ☐ **Plan K** - 50% Cost-Sharing

Additional plans only available to applicants first eligible for Medicare before Jan. 1, 2020.

- ☐ **Plan F** - Basic Benefits, Part A & B Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency, Medicare Part B Excess Charges (100%)
- ☐ **Plan C** - Basic Benefits, Part A & B Deductible, Part A Skilled Nursing Facility Coinsurance, Foreign Travel Emergency

4. GUARANTEED ACCEPTANCE

Please answer the following questions to determine whether your acceptance is guaranteed, without answering health questions.

A. Did you turn age 65 in the last six months? ..... ◯ Yes ◯ No

B. Did you enroll in Medicare Part B within the last six months? ..... ◯ Yes ◯ No

C. Are you disabled and eligible for Medicare in the last six months? ..... ◯ Yes ◯ No

If yes to B or C, what is the Medicare Part B effective date? _____/_____/_____

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 proceed to section 6.

If you answered yes to questions A, B, or C above, your acceptance is guaranteed, and you should not answer health questions. Please proceed to section 6. If you answered no to questions A, B, AND C and are not losing other coverage, please proceed to section 5 to answer health questions.

There are other scenarios that may qualify you for guaranteed acceptance into this Medicare supplement plan, when you lose or terminate health coverage under certain circumstances. You may find a full list of qualifying guaranteed-issue scenarios in *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare,* available at medicare.gov. If you have any question whether you qualify for guaranteed acceptance into this Medicare supplement plan, please contact us or speak with your agent.

5. HEALTH QUESTIONS

A. Based on the diagnosis and/or recommendation of a licensed medical professional, do any of the following apply to you within the past **two years**? ..... ◯ Yes ◯ No

- Have you been hospitalized (more than 24 hours) three times or more, or been recommended to have inpatient surgery that hasn't yet been performed?
- Have you been hospitalized for the treatment of mental or nervous disorders, including alcohol or drug abuse?
- Have you had or been told by your physician you had a heart attack, congestive heart failure, heart valve disorder, heart rhythm disorder, enlarged heart, coronary artery disease (hardening or narrowing of the artery or arterial blockage), carotid artery disease, stroke, aneurysm, or peripheral vascular disease?
- Have you had or been told by your physician you had diabetes that requires insulin; liver disease; or broken bones due to osteoporosis?
- Have you had or received treatment for end-stage renal disease (ESRD), kidney disease, or have you received kidney dialysis?

B. Based on the diagnosis and/or recommendation of a licensed medical professional, do any of the following apply to you within the past **five years**? ..... ◯ Yes ◯ No

- Have you had or received treatment or surgery for cancer (except for non-melanoma skin cancer), Hodgkin's disease, melanoma, or leukemia?
- Have you had, or been recommended to have, any organ transplant other than of the cornea?

C. Have you been diagnosed by a licensed medical professional with one or more of the following **at any time**? ..... ◯ Yes ◯ No

- Alzheimer's disease
- Cerebral palsy
- Cystic fibrosis
- Emphysema
- Hemophilia
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Parkinson's disease
- Rheumatoid arthritis
- Sickle cell anemia
- Systemic lupus

D. Based on the diagnosis and/or recommendation of a licensed medical professional, do any of the following statements **currently** describe you? ..... ◯ Yes ◯ No

- I am confined to a nursing facility
- I am hospitalized
- I am enrolled in a hospice program

STOP: If you answered yes to questions A, B, C, or D in this section, you are not eligible for this Medicare supplement plan at this time. If you need assistance answering these health questions, please contact us at **1-800-221-5696** or speak with your agent.

If you answered no to questions A, B, C, and D in this section, please proceed to section 6.

6. YOUR CURRENT COVERAGE

A. Please review the important statements below.

- 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 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.
- 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 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).

B. Please answer the following questions about Medicaid coverage.

- 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 you answered no, please skip to question C.
If you answered yes, please answer the following questions.

- Will Medicaid pay your premiums for this Medicare supplement policy? ..... ◯ Yes ◯ No
- Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ..... ◯ Yes ◯ No

C. Please answer the following questions about Medicare replacement coverage.

- Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, Medicare HMO or PPO)? ..... ◯ Yes ◯ No

If you answered no, please skip to question D.
If you answered yes, please answer the following questions.

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

START ___/___/___ END ___/___/___

- 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
- Was this your first time in this type of Medicare plan? ..... ◯ Yes ◯ No
- Did you terminate a Medicare supplement policy to enroll in the Medicare plan? ..... ◯ Yes ◯ No

D. Please answer the following questions about Medicare supplement coverage.

- Do you have another Medicare supplement policy in force? ..... ◯ Yes ◯ No

If you answered no, please skip to question E.
If you answered yes, please answer the following questions.

- With what company is your policy, and what type of plan do you have?

_____

- Do you intend to replace your current Medicare supplement policy with this policy? ..... ◯ Yes ◯ No

E. Please answer the following questions about other health insurance.

- Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ..... ◯ Yes ◯ No

If you answered no, please skip to section 7.
If you answered yes, please answer the following questions.

- With what company, and what type of policy?

_____

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

START ___/___/___ END ___/___/___

F. If you answered yes to having other coverage in questions C or D above, please provide the following information about your current coverage.

Company _____ Policy number _____

7. ACCEPTANCE/AGREEMENT

By my signature below, I understand and agree that all statements and answers I've given are complete and true to the best of my knowledge, and that the policy for which I'm applying will be effective only after EPIC approves this application. Evidence of such approval will be issuance of the policy.

I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me to give to The EPIC Life Insurance Company (EPIC) or its legal representative, reinsurers, authorized agents or designees, any and all information in any form (excluding psychotherapy notes) about me concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV, or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by EPIC to determine eligibility for coverage under this Medicare supplement policy, and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that EPIC may release said information to MIB or to EPIC's reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand that I may revoke this authorization by providing advance written notice of termination to EPIC at its office in Madison, Wisconsin, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, EPIC, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 24 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 24-month period.

I understand that I should retain a copy of this completed authorization for my own records, and that a photographic copy shall be as valid as the original. I understand EPIC may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claims and as otherwise permitted by law. EPIC does not disclose protected health information in this application to entities that are not subject to the Privacy Rule unless those entities are under a Business Associate Agreement with EPIC requiring use and disclosure in accordance with the Privacy Rule.

I understand that an insurance agent or broker cannot modify or waive the terms, conditions, or provisions of the insurance policy, application or requirement imposed by EPIC, nor bind coverage or guarantee approval of coverage. I further understand that EPIC, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorneys' fees), I suffer as a result of any improper advice, action or omission on the part of any health care provider.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that I am either listed on the SDN list or associated with an entity listed on the SDN list.

I understand and acknowledge that 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.

I'm applying for a Medicare supplement policy. I've considered all factors and believe this Medicare supplement policy suits my needs. I received the Medicare supplement outline of coverage and the booklet entitled *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* before applying for this policy.

This application is not complete unless signed and dated.
IMPORTANT: Please read and sign section 8 if you are replacing a current Medicare supplement or Medicare Advantage policy with this policy.

This policy has a pre-existing condition limitation and if a physician has provided treatment or recommended treatment for any injury or illness or other condition within the 6-month period prior to issuance of the policy for which I am applying, no coverage will be provided for that illness or injury or other condition until 6 months after the policy has been issued.

Sign Here X

Applicant's signature _____ Date _____

8. IF YOU ARE REPLACING COVERAGE, READ AND SIGN THIS SECTION

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

The EPIC Life Insurance Company

1717 W. Broadway, Madison, WI 53713

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

According to your application or information you have furnished, you intend to terminate existing Medicare supplement coverage or Medicare Advantage plan and replace it with a policy to be issued by Wisconsin Physicians Service Insurance Corporation, underwritten by The EPIC 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 the 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 WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION, THE EPIC LIFE INSURANCE COMPANY, 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. (Check one):

- ◯ Additional benefits
- ◯ Fewer benefits and lower premiums
- ◯ No change in benefits, but lower premiums
- ◯ Other (please specify) _____
- ◯ My plan has outpatient prescription drug coverage, and I am enrolling in Medicare Part D
- ◯ Disenrollment from a Medicare Advantage plan

Please explain reason for disenrollment _____

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.

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

_____

(Signature of agent, broker, or other representative) *Signature not required for direct response sales*

_____

(Printed name and address of issuer, agent, or broker) Agency number

Sign Here X _____ _____

Applicant's signature Date

9. PREMIUM PAYMENT OPTIONS

Please check ONE of the three options.

☐ AUTOMATIC BANK WITHDRAWAL: We electronically transfer your premium directly from your bank account at the frequency you request. When you select this option, **you save 2% on your premium**.

A. Account information

Select one: ◯ I am attaching a voided check to the bottom of this page → **Tape voided check below as shown, then skip to B.**

◯ I will provide the bank account information

Bank name _____

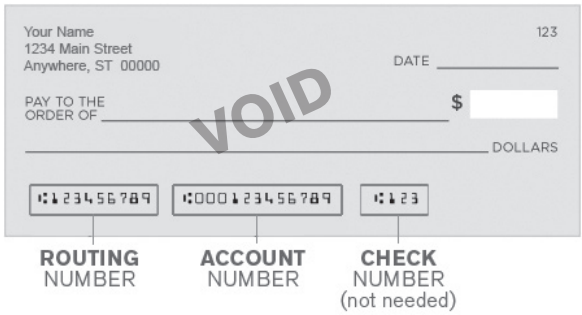
9-digit routing number_____

Account number _____

Type of account:

◯ Checking

◯ Savings (Your savings account number may be found on a bank statement or by contacting your bank)



B. Account holder information

Name _____

Address _____

City _____ State _____ ZIP code _____

C. Frequency and timing of payments

Select one: ◯ Monthly ◯ Quarterly ◯ Semiannually ◯ Annually

Select one: ◯ On the 20th of the month preceding coverage ◯ On the 1st of the coverage month

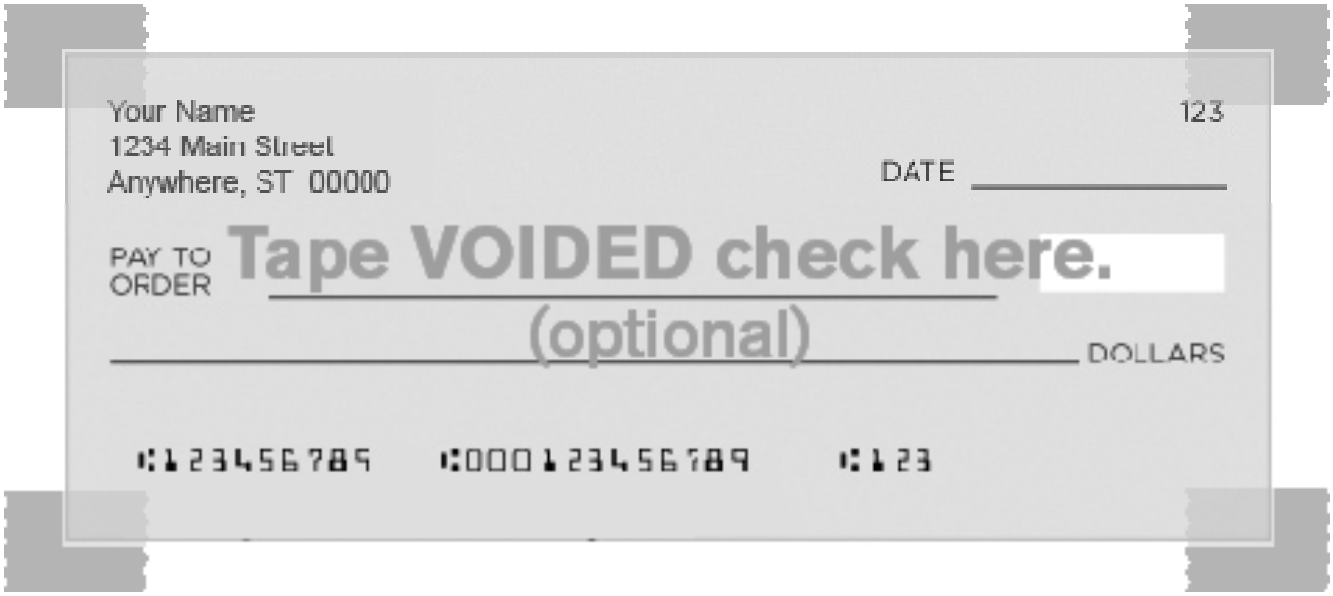
D. Authorization and signature

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify WPS in writing of its termination. My notification must afford WPS and my financial institution reasonable opportunity to act on it. WPS is not responsible for any loss, incorrect delivery, destruction, delay, or interception of this application and its contents by others.

Sign Here ➡ X

_____ _____

Applicant's signature Date



9. PREMIUM PAYMENT OPTIONS (CONTINUED)

☐ DIRECT BILL: We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.

☐ CREDIT/DEBIT CARD: You may set up credit or debit card payments by visiting pay.wpsic.com. Please note that if you do not set up a payment within 5 business days of receipt of your application, you will automatically be enrolled in the monthly direct bill option listed above.

BILL FREQUENCY:

◯ Monthly ◯ Quarterly ◯ Semiannually ◯ Annually

Note: If you choose either of these options, you miss an opportunity to save 2% on your premium.

10. AGENCY FORM

If application is being completed through an agent, he or she must complete the following section.

A. Please list any other health insurance policies you have personally sold to the applicant that are still in force. (If none, please write none.) Also, list any policies you sold to the applicant in the past five (5) years that are no longer in force.

POLICY DESCRIPTION	IN FORCE
_____	◯ Yes ◯ No
_____	◯ Yes ◯ No
_____	◯ Yes ◯ No

B. I asked the applicant all the questions in this application, and the answers are recorded as given to me. ..... ◯ Yes ◯ No

Signed at _____ Date ____ /____/____

Writing agent (print name) _____

Signature of writing agent _____

Florida Agent's License Identification Number _____

Agency name _____

Tax ID number _____

Medicare supplement insurance plans are insured by The EPIC Life Insurance Company, a wholly owned subsidiary of Wisconsin Physicians Service Insurance Corporation, the plan administrator. Neither Wisconsin Physicians Service Insurance Corporation, nor The EPIC Life Insurance Company, nor their products, nor agents are connected with or endorsed by the United States government or the federal Medicare program. EPIC complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex.

The EPIC Life Insurance Company®
A WPS Company

1717 W. Broadway
P.O. Box 8190
Madison, WI 53708-8190