

Figure: 28 TAC §3.3309(f)

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

(Issuer's name and address)

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

According to (your application) (information you have furnished), you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by (Issuer's Name). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or Medicare Advantage coverage only if, after due consideration and acceptance by the replacing issuer, you find that purchase of this Medicare supplement coverage is a wise decision. You should evaluate the need for other accident and sickness coverage you have that may duplicate the benefits provided under this policy.

**STATEMENT TO APPLICANT BY ISSUER (OR OTHER REPRESENTATIVE):**

I have reviewed your current medical or health 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 reasons:

\_\_\_\_\_Additional benefits,

\_\_\_\_\_Same benefits but lower premiums,

\_\_\_\_\_Fewer benefits and lower premiums, and/or

\_\_\_\_\_Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. [optional only for Direct Mailers.]

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_Other(specify)\_\_\_\_\_.

I call to your attention the following items for your consideration:

(1) Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions waiting periods, elimination periods, or probationary periods. The insurer will reduce any time periods applicable to preexisting conditions waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

(3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

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

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Signature of Agent or Other Representative

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Typed Name and Address of Issuer or Agent

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(Applicant's Signature)

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(Date)