

RETURN THIS COPY COMPLETED & SIGNED TO KPS HEALTH PLANS

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

**KPS HEALTH PLANS
P.O. BOX 339
400 WARREN AVENUE
BREMERTON, WA 98337**

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

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a contract to be issued by KPS Health Plans. Your new contract will provide thirty days within which you may decide without cost whether you desire to keep the contract.

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 disability coverage you have that may duplicate this contract.

STATEMENT TO APPLICANT BY ISSUER OR AGENT:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract 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 contract 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) _____

**DO NOT CANCEL YOUR PRESENT CONTRACT UNTIL YOU HAVE RECEIVED YOUR NEW
CONTRACT AND ARE SURE THAT YOU WANT TO KEEP IT.**

Applicant's Name (please print) _____

Applicant's Signature _____ Date _____

Agency Name _____

Agency Address _____

Insurance Producer's Name (please print) _____

Insurance Producer's Signature _____ Date _____

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