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 INSURANCE PRODUCER:

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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