NEW MED-SUPP APP REVIEW

## Important App Changes for 2001

Applicant's Phone # ()	A Name of Accellence					2.	PRINT – Mailing address:					
E-Mail Address       Adv. Effective Date Requested       Date of Similar Age Sex Plan Code         Adv. Effective Date Requested       Date of Similar Age Sex Plan Code       City	1. Name of Applicant						Name					
Adv. Effective Date Requested       Date of Birm       Age       Sex       Pur Core         Vity							No. & St. or Rt. No					
Mode       Day       Yr.         Mode       Day       Previous         Mode       Day       Previous       Day         Mode       Day       Previous       Day       Previous         Mode       Day       Previous       Day												
Image: Contract Conternation Contract Contract Contract Contra	Adv. Effective Date Requested		Age	Sex	Plan Code							
Other spicate in N4. W/l         Automatic Payment Plan         Subject           Of a spicate in N4. W/l         Automatic Payment Plan         Subject         County           Art II: ELIGIBILITY QUESTIONS         County         State         Zp								low:				
City												
Ite control       State       Zp         TO THE BEST OF YOUR KNOWLEDGE:       Ite control       State       Zp         3. Do you have another (or pending applications for)Medicare       Depoint of the applications for)Medicare       Duestions 7:12 not required if you are within 6 months of your enrollment:         in H so, with which company?       Ite applications for)Medicare       Duestions 7:12 not required if you are within 6 months of your enrollment:         (b) If so, do you intend to replace your current Medicare       Yes       No         (c) If so, do you have anny other health insurance coverage that provides benefits similar to this Medicare Supplement policy?       Yes       No         (a) If so, with which company?       Yes       No         (b) What kind of policy?       Yes       No         (b) What kind of policy?       Yes       No         (c) As a Specified Low Income Medicare Beneficiary (SLMB)?       Yes       No         (c) For other Medicaire Beneficiary (SLMB)?       Yes       No         (b) As a Qualified Medicare Beneficiary (SLMB)?       Yes       No         (b) As a Qualified Medicare Beneficiary (QMB)?       Yes       No         (c) For other Medicaire Beneficiary (SLMB)?       Yes       No         (b) As a Qualified Medicare Beneficiary (QMB)?       Yes       No         (c) For other Medicaire	(Not applicable in Nri & VVV)	Automatic Fayment Flam					City County					
TO THE BEST OF YOUR KNOWLEDGE:         3. Do you have another (or pending applications for)Medicare Supplement policy or certificate in force?       Yes No         (a) If so, with which company?       Yes No         (b) If so, do you intend to replace your current Medicare Supplement policy with this policy?       Yes No         (a) Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?       Yes No         (a) If so, with which company?       Yes No         (b) What kind of policy?       Yes No         (a) If so, with which company?       Yes No         (b) What kind of policy?       Yes No         (c) For other Medicare Beneficiary (QMB)?       Yes No         (b) As a Qualified Medicare Beneficiary (QMB)?       Yes No         (c) For other Medicaid medical benefits?       Yes No         (d) As a Qualified Medicare Beneficiary (QMB)?       Yes No         (e) For other Medicaid benefits?       Yes No					(see over)		StateZip					
3. Do you have another (or pending applications for)Medicare Supplement policy of certificate in force?       I is on with which company?         (a) If so, with which company?       I's on with which company?         (b) if so, do you intend to replace your current Medicare Supplement policy with is policy?       I'yes I No         4. Do you have any other health insurance coverage that provides benefits smillar to this Medicare Supplement policy?       I'yes I No         (a) If so, with which company?       I'yes I No         (b) What kind of policy?       I'yes I No         (c) What kind of policy?       I'yes I No         (b) As a Oucvered for medical assistance through the state Medicaire Claim Number?       (east) years, have you been medically advised to have surgery for cataracts, or for joint replacement, or for a heart condition, but not had such surgery?       I'yes I No         (c) For other Medicaire Beneficiary (DMB)?       Yes I No         (b) As a Ouciled Medicare Beneficiary (OMB)?       Yes I No         (c) For other Medicaid medical benefits?       Yes I No         (b) As a Ouciled Medicare Beneficiary (OMB)?       Yes I No         (c) For other Medicaid medical benefits?       Yes I No         (b) As a Ouciled Medicare Beneficiary (OMB)?       Yes I No         (c) For other Medicaid medical benefits?       Yes I No         (c) For other Medicaid medical benefits?       Yes I No         (b) As a Ouciled												
Boyon have a unity of particular graphications for internation?       If The ARSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:         (a) If so, with which company?       Iso, with which company?       If The ARSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES," THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE:         (b) If so, do you intend to replace your current Medicare Supplement policy with this policy?       Ives INA         4. Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?       Ives INA         (a) If so, with which company?       Ives INA         (b) What kind of policy?       Ives INA         5. Are you covered under Medicare Parts A & B?       Ives INA         (card) as sistance through the state Medicaid program:       Ives INA         (a) As a Specified Low Income Medicare Beneficiary (SLMB)?       Ives INA         (b) As a Qualified Medicare Beneficiary (QMB)?       Ives INA         (c) For other Medicaid medical benefits?       Ives INA         (c) For other Medicaid medical benefits?       Ives INA         INVOLUTARY TERMINATION OF COVERAGE: If you voluntarily terminated overage was terminated?       Ives INA         (vacuul three mination?       Ives INA         Ate type of coverage was terminated?       Ives INA         (vacuul three mination?       Ives INA         (b) As a Qualified Medicare Benef						QI	iestions 7-12 not required if you are within 6 months	of your enrollment				
<ul> <li>(a) If so, with which company?</li> <li>(b) If so, do you intend to replace your current Medicare Supplement policy?</li> <li>(c) If so, do you area you ther health insurance coverage that policy?</li> <li>(c) Yes ou covered under Medicare Supplement policy?</li> <li>(c) What kind of policy?</li> <li>(c) Ka you covered under Medicare Parts A &amp; B?</li> <li>(c) Ka you covered for medical assistance through the state Medicaid program:</li> <li>(a) As a Specified Low Income Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicaid medical benefits?</li> <li>(c) For other Medicaid program:</li> <li>(c) For other Medicaid program:</li> <li>(c) For other Medicaid program:</li> <li>(c) For o</li></ul>	Supplement policy or certif	ficate in force?	or)Medic	care	es 🖵 No	IF THE ANSWER TO ANY OF THE FOLLOWING QUESTIONS IS "YES,"						
<ul> <li>(b) If so, do you intend to replace your current Medicare Supplement policy with this policy?</li> <li>(c) Yes on you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?</li> <li>(c) If so, with which company?</li> <li>(c) If so, with which company?</li> <li>(c) What kind of policy?</li> <li>(c) For other Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicare Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicare Beneficiary (QMB)?</li> <li>(c) For other</li></ul>	(a) If so, with which comp	bany?				7.	Are you currently hospitalized, confined to a nursing	a facility				
provides benefits similar to this Medicare Supplement policy?       Pess No         (a) If so, with which company?       Pess No         (b) What kind of policy?       Pess No         5. Are you covered under Medicare Parts A & B?       Pess No         6. Are you covered under Medicare Parts A & B?       Pess No         7. Are you covered under Medicare Parts A & B?       Pess No         8. Are you covered under Medicare Parts A & B?       Pess No         9. Within the past year, have you been medically advised to have surgery for cataracts, or for joint replacement, or for a hear condition, but not had such surgery?       Pess No         6. Are you covered for medical assistance through the state Medicair program:       (a) As a Specified Low Income Medicare Beneficiary (QMB)?       Pess No         (a) As a Specified Low Income Medicare Beneficiary (QMB)?       Yes No       No         (b) As a Qualified Medicare Beneficiary (QMB)?       Yes No       No         (c) For other Medicaid medical benefits?       Yes No       No         (diver dialysis?       Pess No       No         Noutintarity termination?       Reason for termination?       Pess No         (b) As a Qualified Medicare Beneficiary (QMB)?       Yes No       No         10. Wortuntary TERMINATION OF COVERAGE:       If you voluntarily terminated?       Pess No         11. Woluntary terminated?	(b) If so, do you intend to replace your current Medicare Supplement policy with this policy? I Yes I No						you been hospitalized or received Medicare approved home					
<ul> <li>(b) What kind of policy?</li> <li>(c) What kind of policy?</li> <li>(c) What kind of policy?</li> <li>(c) Key, what is your (medicare card)</li> <li>(c) Key ou covered for medical assistance through the state Medicare Claim Number?</li> <li>(c) Key ou covered for medical assistance through the state for internal cancer?</li> <li>(c) Key ou covered for medical benefits?</li> <li>(c) For other Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicare benefits?</li> <li>(c) For other Medicare for match it to this form.</li> <li>(c) For other Medicare for mentated involuntarily, please provide a fyour previous coverage was terminated involuntarily.</li> <li>(c) For other Medicare?</li> <li>(c) For other Medicare?</li> <li>(c) For other Medicare?</li> <li>(c) For other Medicare for interniation of coverage and attach it to this form.</li> <li>(c) Voluntarily terminated involuntarily.</li> <li>(c) For other Medicare?</li> <li>(c) For other Medicare?</li> <li>(c) For other Medicare?</li> <li>(c) For other Medicare for mentiated involuntarily.</li> <li>(c) For other Medicare Choice plan* or Medicare Select policy, please answer the following questions:</li> <li>(c) What type of coverage was terminated?</li> <li>(c) For other Medicare?</li> <li>(c) For</li></ul>	policy? I Yes I No						daily activity, or have you been diagnosed with Gau Disease or any other type of lipidosis, or during the	cher's past				
<ul> <li>5. Are you covered under Medicare Parts A &amp; B?</li> <li>Yes No</li> <li>If yes, what is your Medicare Claim Number?</li> <li>(exactly as shown on your Medicare card)</li> <li>6. Are you covered for medical assistance through the state Medicaid program:</li> <li>(a) As a Specified Low Income Medicare Beneficiary (SLMB)?</li> <li>(b) As a Qualified Medicare Beneficiary (QMB)?</li> <li>Yes No</li> <li>(c) For other Medicaid medical benefits?</li> <li>Yes No</li> <li>(c) For other Medicaid for the notice of terminated involuntarily please provide a topy of the notice of termination?</li> <li>(c) For other Medicare Choice plan the notice of terminated?</li> <li>(c) For other Medicare Select policy, please answer the following questions:</li> <li>(c) Was this the first time you were ever encolled in a Medicare+Choice plan* or Medicare Select policy for less than 12 months?</li> <li>(c) Koutuntarily terminated or Coverage, please attach evidence</li> <li>(c) For outharity terminated?</li> <li>(c) For outharity terminated?</li> <li>(c) For outharity terminated or coverage, please attach evidence</li> <li>(c) For outharity terminated?</li> <li>(c) For outharity terminate?<td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>Yes 🖵 No</td></li></ul>								Yes 🖵 No				
In yes, wirdl S youl       a heart condition, but not had such surgery?       Yes       Not         Medicare Claim Number?       (exactly as shown on your Medicare card)       0.       Within the past year, have you been diagnosed or treated for internal cancer?       10.       Within the past year, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       11.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?       12.       Within the past 2 years, have you been diagnosed or treated for heart valve surgery. Alzheimer's disease, or cirrhosis of the liver?	5. Are you covered under Me			□ Ye	es 🖵 No	<ol> <li>Within the past year, have you been medically advised to</li> </ol>						
<ul> <li>6. Are you covered for medical assistance through the state Medicaid program: <ul> <li>(a) As a Specified Low Income Medicare Beneficiary (SLMB)?</li> <li>(b) As a Qualified Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicaid medical benefits?</li> <li>(d) As a Qualified Medicare Beneficiary (QMB)?</li> <li>(e) For other Medicaid medical benefits?</li> <li>(f) Yes No</li> </ul> </li> <li>11. Within the past 2 years, have you been advised to have kidney dialysis?</li> <li>12. Within the past 2 years, have you been advised to have kidney dialysis?</li> <li>13. Was thin the past 2 years, have you been advised to have kidney dialysis?</li> <li>14. Within the past 2 years, have you been advised to have kidney dialysis?</li> <li>15. Was thin the past 2 years, have you been advised to have kidney dialysis?</li> <li>16. Was a coverage was terminated involuntarily, please provide a popy of the notice of termination of coverage was terminated?</li> <li>17. Was this the first time you were ever encolled in a Medicare+Choice plan or purchased a Medicare Select policy for less than 12 months?</li> <li>17. VoLUNTARY TERMINATION OF COVERAGE:</li> <li>18. you voluntarily terminated you present coverage, please attach evidence</li> <li>19. You voluntarily terminated you present coverage, please attach evidence</li> <li>19. You voluntarily terminated you present coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtite A, Chapter 1 of PL. 105-33, and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans, (2) Medicare leavings account</li> </ul>	Medicare Claim Number?							🗆 Yes 🖵 No				
<ul> <li>(a) As a Specified Low Income Medicare Beneficiary (SLMB)?</li> <li>(b) As a Qualified Medicare Beneficiary (QMB)?</li> <li>(c) For other Medicaid medical benefits?</li> <li>(c) For other Medicaid benefits?</li> <li>(c) For other Medicaid medical benefits?</li> <li>(c) For other Medicaid benefits?</li> <li>(c) For other Medicare Choice plan 'providus coverage to this form.</li> <li>(c) Voluntarily terminated your present coverage, please attach evidence folicy?</li> <li>(c) For overage was terminated?</li> <li>(c) For overage was terminated?</li> <li>(c) For overage to this form.</li> <li>(c) Hou voluntarily for the Medicare Choice plan or Medicare Supplement ploicy before applying for the Medicare Supplement ploicy before applying for the Medicare Supplement plan?</li> <li>(c) For overage was terminated?</li> <li>(c) For overage was terminated?</li> <li>(c) For overage was terminate?</li> <li>(c) Hou voluntarily terminate core plans which provide health care services, including but not limited to health maintenance organization and prefered provide corganizati</li></ul>	<ol> <li>Are you covered for medical Medicald program:</li> </ol>											
(b) As a Qualified Medicare Beneficiary (QMB)?       Yes       No         12. Within the past 2 years, have you been advised to have kidney dialysis?       Yes       No         ART III       INVOLUNTARY TERMINATION OF COVERAGE:       If you voluntarily terminated coverage under a Medicare+Choice plan* or Medicare of termination?       Medicare Select policy, please answer the following questions:         NMat type of coverage was terminated?       If you voluntarily terminated coverage not a Medicare Choice plan or purchased a Medicare Select policy for less than 12 months?       Yes       No         1. VOLUNTARY TERMINATION OF COVERAGE:       If you voluntarily terminated or coverage not for termination?       1. Was this the first time you were ever encolled in a Medicare+Choice plan or purchased a Medicare Select policy for less than 12 months?       Yes       No         1. Voluntarily terminated you present coverage, please attach evidence       Medicare Select policy for less than 12 months?       Yes       No         2. Did you have a Medicare-Choice plan or Medicare       Medicare Select policy?       Yes       No         2. No that type of coverage was terminated?       If yes, with which Company and which Medicare       Yes       No         2. No that type of coverage to this form.       If yes, with which Company and which Medicare       Yes       No         2. No that type of coverage to this form.       If yes, with which Company still offering that Medicare Supplement plan?       Yes	(a) As a Specified Low In	As a Specified Low Income Medicare					treated for heart valve surgery, Alzheimer's disease, or					
(c) For other Medicaid medical benefits?       Yes       No       kidney dialysis?       Yes       No         ART III       INVOLUNTARY TERMINATION OF COVERAGE:       If you voluntarily terminated coverage under a Medicare+Choice plan* or Medicare Select policy, please answer the following questions:       1. Was this the first time you were ever enrolled in a Medicare+Choice plan* or Medicare Select policy, please answer the following questions:         What type of coverage was terminated?       If you voluntarily termination?       Yes       No         . VOLUNTARY TERMINATION OF COVERAGE:       If so, did you have the Medicare+Choice plan or purchased a Medicare Select policy for less than 12 months?       Yes       No         . Voluntarily terminated your present coverage, please attach evidence       If yes, with which Company and which Medicare       Yes       No         . Voluntarily terminated?       Is that Company still offering that Medicare Supplement plan?       Yes       No         . Voluntarily terminated your present coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of PL. 105-33, and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans, (2) Medicare lawings account	(b) As a Qualified Medica	are Beneficiary (QMB	)?	U Ye	es 🖵 No							
INVOLUNTARY TERMINATION OF COVERAGE:         f your previous coverage was terminated involuntarily, please provide a         f your of the notice of termination of coverage and attach it to this form.         What type of coverage was terminated?         Date of termination?         Reason for termination?         I. VOLUNTARY TERMINATION OF COVERAGE:         typu voluntarily terminated your present coverage, please attach evidence         f previous coverage to this form.         Vant type of coverage was terminated?         L. VOLUNTARY TERMINATION OF COVERAGE:         typu voluntarily terminated your present coverage, please attach evidence         f previous coverage to this form.         What type of coverage was terminated?	(c) For other Medicaid me	-,										
your previous coverage was terminated involuntarily, please provide a       Medicare Select policy, please answer the following questions:         opy of the notice of termination of coverage and attach it to this form.       I. Was this the first time you were ever enrolled in a Medicare-Choice plan or purchased a Medicare Select policy?       Yes \No         what type of coverage was terminated?       I. Was this the first time you were ever enrolled in a Medicare-Choice plan or purchased a Medicare Select policy?       Yes \No         what type of coverage was terminated?       If so, did you have the Medicare+Choice plan or Medicare Select policy?       Yes \No         voluntarily terminated your present coverage, please attach evidence f previous coverage to this form.       2. Did you have a Medicare Select policy?       Yes \No         what type of coverage was terminated?       If yes, with which Company and which Medicare Select policy?       Yes \No         2. Did you have a medicare+Choice plan or Medicare Select policy?       If yes, with which Company and which Medicare Select policy?       Yes \No         what type of coverage was terminated?       Is that Company still offering that Medicare Supplement plan?       Yes \No         what type of coverage was terminated?       Is that Company still offering that Medicare Supplement plan?       Yes \No         what type of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtile A, Chapter 1 of PL. 105-33, and includes: (1) Coordinated care plans which provide health care services, including bu												
2. Did you have a Medicare Supplement policy before applying for the Medicare-Choice plan or Medicare Supplement policy before applying for the Medicare-Choice plan or Medicare Supplement policy before select policy? If yes, with which Company and which Medicare Supplement plan? Date of termination? Reason for termination? Is that Company still offering that Medicare-Choice plan means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of P.L. 105-33, and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans; (2) Medical sevings account	f your previous coverage was t copy of the notice of termination What type of coverage was terr	terminated involuntar n of coverage and att minated?	ily, plea ach it to	o this fo	orm.	Me 1. \ 0	dicare Select policy, please answer the following que Vas this the first time you were ever enrolled in a Mer or purchased a Medicare Select policy? i so, did you have the Medicare+Choice plan or	stions: licare+Choice plan IYes INo				
Visual Visuality terminated your present coverage, please attach evidence f previous coverage to this form.       Select policy?       Yes □No         What type of coverage was terminated?						2. Did you have a Medicare Supplement policy before						
What type of coverage was terminated?       Supplement plan?         Date of termination?       Is that Company still offering that Medicare Supplement plan?         Is that Company still offering that Medicare +Choice plan means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of PL. 105-33, and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (2) Medical seving account	If you voluntarily terminated your present coverage, please attach evidence						Select policy? IYes We If ves. with which Company and which Medicare					
Date of termination? Reason for termination? Is that Company still offering that Medicare Supplement plan? YesNo Medicare+Choice plan means a plan of coverage for health benefits under Medicare Part C as defined in Section 1859 found in Title IV, Subtitle A, Chapter 1 of PL. 105-33, and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a pointo-f-service organization plans (and prefered by provide-services and organizations) and orgenered provider organization plans (and prefered by provide secound to the secound organizations).	What type of coverage was terr	minated?				ŝ						
P.L. 105-33, and includes: (1) Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; (2) Medical savings account	Date of termination?	Reason for termin	ation?				s that Company still offering that					
	P.L. 105-33, and includes: (1) C or without a point-of-service opti	oordinated care plans ion), plans offered by	which p provider-	orovide -sponso	health care pred organiz	serv atior	ces, including but not limited to health maintenance organis, and preferred provider organization plans; (2) Medica	anization plans (with				

	MA12 is available in jurisdictions marked "X" at press time.											
STATE APPROVAL CHART	AL AK AZ	X	GA HI ID	XXX	MD Z Z	x	NC ND OH	x x	TX UT VT	××		
	AR CA	x	IL IN	x	MS MO	X	OK OR	X X	VA WA	X		
	CO CT	X X	KS	X	MT NE	X X	PA RI	XX	WI	X		
	DE DC FL	X X X	KY LA ME		NY NH NM	X	SC SD TN	X X X	WY	X		

Check out the application changes in Parts I, II and III highlighted in blue — see sample at left. (For use after 1-01-2001)

\*

## **Part I: Applicant Information**

\*

**E-mail:** We are now requesting the proposed insured's e-mail address (if applicable) in order to better serve customers' needs.

**Draft Date:** A draft date for policyholders using the Automatic Payment Plan enables customers to have the bank draft coincide with the arrival date of their Social Security check.

## **Part II: Eligibility Questions**

**Waiver:** Health questions are waived if the applicant is within 6 months of Medicare enrollment or is otherwise qualified for open enrollment.

**Question 8.** We have added a question on Gaucher's Disease which is a form of lipidosis (any disorder of fat metabolism). The term lipid refers in general to a fat or fatlike substance. One form is Gaucher's Disease; Niemann-Pick is another form of lipidosis. Other forms are very rare and generally result in death in infancy. Gaucher's Disease is associated with an enlarged liver and spleen, increased skin pigmentation and painful bone lesions. Enzyme replacement therapy is one way to treat this disease.

## **Part III:**

This entire section of the application is new. Applicants must answer whether they were involuntarily disenrolled or voluntarily terminated their coverage.

**Ordering Information:** *If your state has approved the MA12, you can place your order now to receive 2001 Med-Supp supplies.* Phone: 1-800-285-3676; Fax: 1-405-752-9341 or E-mail: uaagentsupply@torchmarkcorp.com.