Aflac Medicare Supplement Sales Guide

Content subject to change to ensure compliance with Tier One Insurance Company and Aetna Life Insurance Company requirements. To the extent there is any conflict between the descriptions in this guide and the terms of your contract with Tier One Insurance Company, the terms of the contract control.

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Helpful hint: If you'd like to search for a specific term, just press Ctrl+F.

I. Agent Resources

Agent Resources

Aflac Senior Agent Website

Aflac Medicare Supplement product information is available at www.SellAflacMedSupp.com. Additional information about the product requires agent appointment to access the Aflac Senior Agent Portal (ASAP).

Aflac Senior Agent Portal (ASAP)

The Aflac Senior Agent Portal is accessible from the Aflac Senior Agent website at http://www.sellaflacseniorplans.com.

The Product & Tools section of the portal includes product information and availability, commission schedules, underwriting drug list, alerts and messages, and information regarding anti-money laundering. The My Business section of the portal includes your agent profile and any downline agents (as applicable). This section also includes information about your book of business to include: policies, pended business, and policies at risk for lapse. The Communication section of the portal includes all current and past communications to you.

Additionally, the portal is the gateway to the Quote and Enroll tool.

Agent secure log-in

Under the Secure Login section, click on “Agents” and sign in with the username and password you created during onboarding. If this is the first time you’ve used our website, click on the “Register Now” button after you click “Agents” to register your account.

If you need assistance logging in to the agent secure site, please contact the Agent Services team at **833-504-0336**.

Note: If you ever need to change your password, click “your profile” in the upper right hand corner after you’ve logged in.

Agency secure log-in

If you’re an individual agent who owns an agency, you’ll need to register on the website twice. Register once for you, and once for your agency.

Agent communications

It’s quick and easy to stay in the know. Just make sure you have a current email address on file with us and we’ll keep you updated about: products, training, operations, and more.

We send communications to the email address you gave us when you first contracted with Tier One. To start receiving our communications at a new email address, or if you’re not getting our communications, you can update your email by logging in to the Aflac Senior Portal or by contacting the Agent Services team.

And you can always access an archive of past communications on Aflac Senior Agent Portal (click Communications on the main menu).

The following email alerts are available for you to setup within Aflac Senior Agent Portal.

- Schedule Pages for applications submitted
- Applications that have been submitted/received
- Applications that are declined
- Notification of policies issued
- To Applicant - Enrollment Approval
- To Applicant - Enrollment Submission
- Applications that are missing eligibility information
- Commission statement postings with payment notification
- Policies that require immediate attention (EFT rejected)
- Policies that require immediate attention (Member Cancellation)
- Applications that require immediate attention (NIGOs)
- Policies that require immediate attention (potential lapses)
- Policies that will receive a rate change

Agent Services team

The Agent Services team is focused on your needs as a new or experienced agent/agency. We want to help you grow your business.

Services Offered

The Agent Services team can help answer your questions about:

- Product details and benefits
- Placing sales supply orders
- Agent and agency communications
- Navigation and login support for Aflac Senior Agent Portal
- Submitting a new application using the Aflac Quote and Enroll tool or using paper

Additional assistance available:

- New application rate quotes
- Drug/formulary lookup
- Checking active appointment status for products and states
- Providing contact information for other departments
- Updating agent email and mailing addresses

The Agent Services team

- Phone: **833-504-0336**
- Email: information@aflac.aetna.com
- Hours: Monday through Friday, 8:00 a.m. - 5:00 p.m. CT

II. Licensing, Contracting and Appointment

Key terms

- License: The state Department of Insurance will issue a license to producers who submit an application to solicit business in that state. The agent must receive their license from the state before they request to contract with Tier One Insurance Company (Tier One).
- Contract: An agreement between the agent and Tier One that must be signed. Once executed, the contract is a legally binding document.
- Appointment: A registration with state insurance departments that a producer is acting on behalf of Tier One and has the right to sell Tier One products in that state.
- Upline: A firm, agency, organization or person with downline agents.
- Downline: A person or entity whose contract connects to one or more uplines; or a licensed-only agent.

Contract types

- Agent contract: A Licensed Only Agent (LOA) is an agent who is assigned to and supervised by a General Agent or a Marketing General Agent (upline). We don't pay commissions directly to LOA agents. LOA compensation is paid by an LOA's upline.
- General Agent contract: A General Agent (GA) is an agent who is assigned to and supervised by a Marketing General Agent (upline). A GA may manage other GAs, agents or LOA agents. We pay commissions directly to GA agents.
- Marketing General Agent contract: A Marketing General Agent (MGA) is a GA who manages multiple agencies, GAs, agents and LOA agents. We pay commissions directly to MGAs.

Contracting

Initial contracting

The contract and appointment process begins with an upline agent inviting you to contract. Invitations to contract are sent by one of two system, the Aflac onboarding tool or SuranceBay.

Agent background check and review process

As part of the contracting process, we perform standard background checks that include, but are not limited to:

- Criminal Search
- Professional License Verification

If the background report is clear, we'll complete the final steps of the contracting process. If a background report is not clear, it will be reviewed by our contract review team to decide whether Tier One will move forward with the contracting process or if the application to contract will be declined.

When an applicant is under review, we'll send a pre-adverse action letter and a copy of the applicant's background report to the applicant's email address. If no email address is available, the letter and report will be mailed to the applicant. During the review process, the applicant has ten business days from the date of the letter to provide a response.

If the applicant wishes to dispute the accuracy of the information in the background report, the applicant should contact Applicant Insight, the consumer reporting agency that provided the report, at **1-800-771-7703 x 2048**.

The applicant may submit any additional documentation for review with background findings by email to backgroundcheckinfo@aflac.aetna.com.

- If the applicant is approved, we'll send a welcome letter to the agent/agency and their upline.
- If the applicant is not approved, we'll send a decline letter to the agent/agency and their upline.
- If the application is not approved, the applicant can re-apply any time that they feel their background has changed and would like to start a new application and review process.

Appointments

After contracting, we'll appoint you with Tier One Insurance Company for the products for which you are licensed.

When we launch new products or change entities, we'll auto-appoint you if you're licensed and have submitted business in the past 12 months.

Just in Time Appointment (JIT)

In JIT states, once contracting is completed and a new business application is submitted, Aflac will process your appointment with the appropriate JIT state. This means we submit the appointment agreement to a state Department of Insurance (DOI) once you've submitted your first application in that state.

Non-appointment states

The following states do not require producer appointments (Tier One will maintain a list of licensed agents):

- Alabama
- Arizona
- Colorado
- Illinois
- Indiana
- Maryland
- Missouri
- Oregon

Pre-appointment states

If an application is submitted in a pre-appointment state with an agent signature date that's earlier than the state appointment date, the application will not be accepted. The following states require pre-appointment:

- Alabama
- Kentucky
- Louisiana
- Montana
- Ohio
- Pennsylvania
- Utah
- Vermont
- Washington
- Wisconsin

For states requiring pre-appointment, you may fax your license to Agent Contracting/Licensing fax: **855-571-3847**.

Appointment Status, Demographic changes, Terminations

Checking on appointment status

An agent's upline may use Aflac Senior Agent Portal to see updates made to an agent's contracting status and appointments, which will appear 24 hours after being completed.

Contracted agents may go to "My Profile" section to see products and state appointment approval status.

Demographic changes

You may fax changes to Agent Contracting/Licensing fax: **855-571-3847**. If you want to change the name on your agent record, we'll need a copy of your license showing your new name.

If your agency name is changing, you'll need to send us a detailed request and a copy of your agency license showing the new agency name.

If your agency Tax ID is changing, it is considered a hierarchy change and we'll have to issue your agency a new writing number.

Terminations

All agent/agency appointment terminations are reviewed by our business leadership. In order to comply with state timing requirements, appointment terminations are processed in our system on the same day we send the termination letter to the agent. Typically, the effective date of the termination is 15 days after the notice is sent. The effective date may vary depending on the reason for the termination.

In the event an agent terminates by choice or for a reason other than "for cause," we require a six-month waiting period before they can reapply.

Hierarchy changes and transfers

Hierarchy changes

If you or one of your agents needs a hierarchy change, here are tips to help speed up the process. Uplines can fax hierarchy change requests to **855-571-3847**.

Situations that require a hierarchy change:

- Changing agent commission level (LOA to GA, GA to LOA)
- If moving GA to GA, the GA must remain at the same commission level they were for 6 months
- If moving LOA to GA, the new GA can start at any commission level
- Adding or removing intermediaries
- Adding or removing an agency
- If remaining under the same hierarchy, the level can be changed
- Recent termination (within 6 months)
- New upline/NMO
- Principal agent changes
- When an agent or agency buys another
- Agency name/Tax ID change (requires court documents with new Tax ID number conversion and licenses with new agency name)

Transfers

Required documents for single agent transfers:

- Contract
- Producer information form (PIF)
- Commission advance addendum
- W-9
- A release letter from the current upline (if agent produced within previous 6 months) or intent to transfer (the transferring agent must email an Aflac Relationship Manager and copy their current upline; the agent can continue to produce for 6 months, then the new upline will email hierarchy change paperwork to the Regional Sales Specialist)

Required documents for agent/agency transfers with a downline:

- Contract
- Producer information form (PIF)
- Commission advance addendum
- W-9
- A release letter from the current upline (if agent/agency produced within previous 6 months) If you have any questions, contact the Agent Services team at **833-504-0336**.

III. Compensation

Compensation overview

"Compensation" means first year, renewal and override commissions and other forms of remuneration earned by an agent in connection with the sale of our insurance products.

In addition to the following overview, be sure to refer to your contract. To the extent there is any conflict between the description below and the terms of your contract with Tier One, the terms of the contract apply.

Commission

Marketing General Agents and General Agents are paid a commission for each member they enroll in an Aflac product in accordance with their contract.

Commissions for licensed-only agent (LOA) sales are paid directly to their upline.

We calculate commissions on the commission cycle after the premium is applied to the policy. When a policyholder pays modal premium, our system calculates commission payment based on your commission schedule and will disburse on the next available commission cycle.

Commission information can be found on the Aflac Senior Agent Portal.

Payment frequency

The compensation year is January 1 through December 31.

We strongly recommend signing up for EFT. Commissions are paid twice weekly for those signed up for EFT, with cycles running on Wednesdays and Saturdays. Due to your individual bank's internal procedures, it may take up to 48 hours before you receive your commission payment.

If you don't sign up for EFT, we will mail you a check for your commissions. Checks are printed on Tuesdays and are only mailed once per week. Keep in mind that our system will wait until your commission total is over $25 before producing a check.

We send your payment using the address or EFT information we have on record.

If you need to change the address or EFT information for an agent/agency, send your changes to commissions@aflac.aetna.com.

- EFT updates require submission of the Agent EFT authorization form.
- Address changes will apply as applicable to LOAs as well.

Based on your contract, you have 45 days to object to payment and calculations on a commission statement.

Advance commissions

- Advance commissions are paid one time per Aflac-affiliated policyholder.
- You must be set up for advance commissions prior to the signature date on the application.
- You must be setup for EFT to be eligible for advance commissions. If setup for advance commissions, but your EFT commission payment is rejected twice, the commissions advance will charge back to your agent commissions account and change from “advance” to “paid as earned.”
- Only policy premiums paid by EFT are eligible for advance commissions. If your policyholder is paying their premium by direct bill, that policy is not eligible for advance commissions.
- Advance commissions are not paid on policies issued to the agent and the agent’s immediate family members. We define immediate family members as your spouse, domestic partner, child, mother, father, sister or brother.
- Interest is charged on Medicare Supplement advanced commissions.

Chargebacks

If a policy is cancelled, withdrawn or not taken within the first 30 days of policy receipt, 100% of the premium will be refunded to the applicant and 100% of commissions will charge back to the agent.

If a policy is cancelled after 30 days, the premium and commissions will be prorated.

If a policy is rescinded for material misrepresentation within the two-year contestability period, commissions will charge back to the agent.

Unearned commissions

If you are advanced commission for a policy and the policy is cancelled, the advance will be considered unearned commission. Unearned commission will charge back to your agent commission account. If a chargeback causes your agent commission account balance to be negative, you won’t receive commission payments until commissions from new submitted business bring your agent commission account positive again.

Replacements

Replacement policy commissions are paid as earned; no advance commissions are paid on a replacement policy, regardless of how long it has been since termination. The first-year commission rate on a replacement policy is 90% of the producer’s current commission rate.

Conversions

No commission is paid on the conversion to term insurance by a child covered on a children’s term insurance rider.

How termination affects compensation

How termination affects compensation

If you are terminated, but still in good standing, you will continue to receive renewal commissions according to your commission schedule.

If you are terminated for cause, we will cancel your compensation payments in accordance with your contract.

Recovery process for terminated agents with debit balances

If you are terminated and have a debit balance on your agent commission account, we will pursue collection of debt.

Assignment of compensation

An assignment of compensation (AOC) is an agreement between two parties to direct commissions to another agent or agency.

You can revert commissions to your agency (GA to GA) or to your personal SSN (LOA to GA). You can sell your block of business to another agent or agency.

- Your status and state appointments will be terminated.
- If you request to be re-contracted, you must submit new contract paperwork.

Any and all debit or advance balances must be paid in full, or a payment arrangement approved by the Debit Consultant must be agreed to before we complete the Assignment of Commissions.

The Assignee will assume the tax liability for the reverted commissions. The commissions will be reported to the IRS under the Assignee Tax ID# from the date the assignment was completed. These commissions are considered renewals only.

Items needed:

- Assignment of Compensation form — Pages 1 & 2
- W9 form — required for new Agencies
- Explanation of reason(s) requesting Assignment of Commission
- Bill of Sale — if applicable
- Legal documents — if applicable
- EFT Authorization form — for direct deposit

Assignment of commissions for a deceased agent

A deceased agent's commissions will be payable to his/her surviving spouse per agent contract. If the agent does not have a surviving spouse, we will honor legal documents such as a will, trust or court-ordered paperwork that indicates the commissions will be payable to other family members or his/her estate.

Items needed:

- Death Certificate of deceased agent
- W9 form — for surviving spouse
- Other legal documents as noted above

1099 forms
Commissions are reported via the Internal Revenue Service (IRS) 1099 process. 1099 MISC forms are postmarked to all eligible recipients by January 31 of a given year and mailed to the payee address on file.

A 1099 MISC form will only generate to an agent if annual earnings from Tier One are $600 or above.

If earnings are less than $600, agents can obtain earning totals by visiting our secure agent website and viewing their commission reports. Note: The last statement date in December pays in January, so those earnings count toward the following tax year. (Example: A 12/22/22 statement date will count toward 2023 taxes, as payment is not generated and sent until after 1/1/23.)

- Aflac will mail 1099s on January 31 for the prior tax year.
- If you need another copy of your 1099, we can fax or mail you a duplicate.
- We can't send your 1099 to your email address.
- If you need to change information on your 1099, please call the Commissions department.

Commissions questions
Contact commissions@aflac.aetna.com with any commissions questions or issues that cannot be resolved by your upline.

IV. Policy and Rider Information

Policy Information
Policy Resources
Various policy resources are available on http://www.SellAflacMedSupp.com, including the Medicare Supplement coverage map, brochures, marketing materials, recruiting fliers and emails.

Available Plans
In most states, available plans include Plans A, F, G and N. Note that Plan F, where available, is only available for people first eligible for Medicare before 2020.

Household Discount
Unlike some other carriers who only offer a Medicare Supplement household discount if each resident enrolls in their Medicare Supplement Plan, Aflac offers a 10% discount if your clients meet either of the following conditions:

- reside with their spouse, including civil union/domestic partner; or
- have been living with a family member who is age 50 or older for the last twelve months.

Reference each state's outline of coverage for details of the household discount. Also, for the purpose of this discount, a civil union partner or domestic partner will be considered a legal spouse when such partnerships are valid and recognized in the applicant's state of residence.

Key Features

- No pre-certification or pre-authorization needed for care: clients may visit any provider that accepts Medicare. A physician referral may be required for specialist, diagnostic, laboratory, or other facility care.
- Benefits stay the same: with a standardized plan, benefits remain the same year after year.
- Portable coverage: clients are not restricted to the use of a provider network. If they move or travel, the coverage goes with them.
- 12-month rate guarantee: no rate increases for the first 12 months: on each anniversary of the effective date, premiums will increase due to an increase in age. The renewal premium for the policy will be the renewal premium then in effect for your client's attained age.
- Guaranteed renewable: as long as premiums are paid, benefits will remain the same for the life of the policy. Your clients will not have to worry about reduced benefits or canceled coverage, regardless of their age or health.
- 30-day free look: clients can return any policy for any reason within 30 days after receipt for a full refund of all premiums paid.

See policies and outline of coverage for each state for specific details, limitations and exclusions.

V. Marketing Materials

How to order sales supplies

1. Log in to Aflac Senior Agent Portal.
2. Click Products & Tools.
3. Select Order Supplies / Download Forms.
4. Order materials based on your applicant's residence state since items may vary by state.
5. Choose a Kit instead of individual items to assure you have all required documents to provide to your applicant and submit an application.

Receipt of supplies will vary depending on delivery state. Orders are shipped from our fulfillment center in Charlotte, North Carolina. If you have time sensitive needs, consider downloading materials instead.

It's easy to order the supplies you need to sell our products. Once you've logged in to the Aflac Senior Agent Portal, go to Products & Tools, then Order Supplies/Download Forms.

Make sure you're ordering materials based on your applicant's state of residence since sales materials and availability vary by state.

Also, if you order a kit instead of individual items, you can be sure that you have all the required documents to submit your application.

Our order fulfillment is completed by Donnelley Financial Solutions in Charlotte, North Carolina.

VI. Submitting Business

Application options

Getting started

Electronic applications are efficient and expedite underwriting, new business processing and policy issue.

- Before completing an application the agent must have an agent writing number.
- You should review the policy details and ensure that your applicant understands the costs and benefits.
- Always take enough time with your applicant to ensure they fully understand all application questions and terminology.

Applications may be submitted using the electronic application process or paper. Applications must include all pages of the application, HIPAA form, replacement form (if applicable) and any state-required forms.

Electronic Applications (eApp)

You can complete and submit online applications for Aflac Medicare Supplement using the Quote and Enroll tool. Go to Aflac Senior Agent Portal and click Quote and Enroll from the Home page Quick Links.

- One login – from http://www.sellaflacseniorplans.com
- Multi-device capability — runs on laptops, desktops and tablets, as well as mobile
- Security question and email signature options
- Applicant-specific guidance — based on answers to questions
- Submit in real time — processing begins immediately
- Rapid visibility to submitted applications — an online report in 30 minutes

The eApp system provides a preliminary quote as the first step of the application process. A mobile rate quote is not available at this time.

To start an eApp, you must first email an eKit to the applicant from the Aflac Senior Agent Portal.

Selecting an initial amount and coverage type is required to start an application. After completing all the application health questions and determining the applicant's eligibility, the amount may be adjusted to meet their needs and budget. After entering the new coverage, click "Re-quote" button.

More than one product can be selected when using eApp; licensing rules apply. Once one product is completed, the application process will flow to the next product. Core applicant information only needs to be entered once.

The applicant's Social Security Number is required to complete an eApp.

Paper Application Considerations

- Paper applications must be submitted within 30 days of the application signature date.
- Applications must be submitted within 15 days from the pre-approval date.
- If you make corrections to the application before the application is submitted, your applicant must strike over and initial the correction. Don't use white-out.
- If your applicant is paying by check, the application and check must be submitted together by mail.
- Do not fax the application and mail the check.

Paper application may be faxed or mailed to: **Aflac, P. O. Box 14863, Lexington, KY 40512, Fax: 855-291-0553**. If submitting a paper application via fax, a cover sheet is required.

Application reminders

- Use the online rate quote tool or manually calculate the premium using the modal factors outlined.
- While you must select a coverage amount and policy type at the start of the electronic application/enrollment, you may adjust the coverage amount upon completion of the application health questions.
- All health questions must be asked as written on the application, and the answers must be recorded as given by the applicant.
- You must select the premium mode and payment method on the application.
- The "age last birthday" is the applicant's age at the time of effective date.
- Effective date is defaulted to application signature date unless one is chosen.
- For paper apps, a completed HIPAA form is required with all application submissions.
- While all dates on forms do not have to be the same, all dates on a form should be less than two months in the past so we have current information.

Medicare Supplement Application Types

Review and clarify the difference between underwritten, Open Enrollment, and guaranteed issue applications. Refer to the CMS produced guide Choosing a Medigap Policy for details.

Underwritten applications

Any applications that don't qualify as Open Enrollment or guaranteed issue applications are underwritten. All underwritten applications require a completed application to include the Health Questions section as well as a completed authorization to obtain (HIPAA) form is required with application submissions.

Open Enrollment

During a person's Medicare Supplement Open Enrollment Period, an applicant cannot be refused coverage. Open Enrollment lasts for 6 months beginning on the first day of the month a person is both 65 or older and enrolled in Medicare Part B. Some states have additional Open Enrollment Periods for people under 65 that are Medicare eligible due to disability or End-Stage Renal Disease (ESRD). After a person's Open Enrollment Period, an applicant will be subject to underwriting, unless eligible for guarantee issue. Open Enrollment policies are issued with preferred (nonsmoker) rates.

Guaranteed Issue Rights

Guaranteed issue rights provide the opportunity to buy Medicare Supplement after the Open Enrollment Period without being subject to underwriting. Guarantee issue policies are issued with preferred (non-smoker) rates. Plan F is guarantee issue for those eligible for Medicare prior to 2020. Plan G is guarantee issue for those eligible for Medicare in 2020 and later. Plan N is not available for guaranteed issue in most states The most common situations for guarantee issue are as follows:

- if a Medicare Advantage Plan member moves out of their plan's service area or the plan ceases to be available to the member,
- if a Medicare Select policyholder moves outside the service area,
- if a member of an employer group health plan or union that is secondary to Medicare loses coverage,
- if a person wants to switch to Original Medicare within the first year of coverage of a person who joined a Medicare Advantage Plan when first eligible for Medicare Part A at 65,
- if a person wants to switch back to Original Medicare within the first year of switching to Medicare Advantage,
- if a Medicare Supplement policyholder loses coverage because their insurance company goes out of business,
- if a person drops their Medicare Advantage Plan because the company hasn't followed the rules, or misled the member.

Guaranteed issue requirements

Applications for coverage under guarantee issue rights must be submitted within 63 days of coverage loss to include:

- Completed application – Health Questions should not be answered
- A replacement form is required if prior coverage is noted within the Eligibility Questions section
- Proof of creditable coverage

Creditable coverage documentation is required as outlined below for the most common situations.

Guaranteed issue (GI) applications must be submitted with the required creditable coverage documentation. Federal and state guidelines outline eligibility for GI applications. Please consult the Department of Insurance for qualifying events in an applicant's state.

Qualifying event	Documentation required
Involuntary loss of own group coverage	Termination letter or creditable coverage on provider letterhead — should include applicant name and dates of coverage
Involuntary loss of dependent group coverage	Same as above, but if individual not named on letter, will also require ID (benefit) card
Medicare Advantage plan leaving area	Notice of termination from provider — should include applicant name and date coverage will end
Medicare Advantage plan stops providing care	Notice of termination from provider — should include applicant name and date coverage will end
Applicant moves out of the service area	One of the following: Notice of termination letter (preferred), copy of utility bill or driver's license with old address
Prior Medicare Supplement coverage went to Medicare Advantage plan and disenrolled within 12 months	1) Proof of Medicare Supplement: schedule page, copy of original application or copy of ID card 2) Proof of Medicare Advantage Plan: Medicare Advantage ID card, copy of cancellation request letter from applicant to Medicare Advantage carrier
Initial trial right period	One of the following: Copy of Medicare Advantage plan ID card, schedule page, original application for coverage, handwritten letter requesting cancellation
Birthday and anniversary rules	Refer to your stated Department of Insurance for specific rules, such as birthday and anniversary rules
Loss of Medicaid (GI eligibility is only available in the following states: KS, ME, OR, TN, TX, UT, WI, MT)	Copy of Medicaid termination letter — should include applicant name and date coverage will end
Involuntary or Voluntary loss of COBRA	Copy of proof that applicant was on COBRA or just came off of COBRA. Proof must include name and end date.

Anniversary and Birthday Rules

California birthday rule

- California provides a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.
- 90-day enrollment period, beginning 30 days prior to your applicant's birthday.
- Application must be signed (application signature date) within 90-day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement cover age that includes plan description and effective dates, such as an ID card or Schedule Page.
- Application must be marked as Open Enrollment.

Idaho birthday rule: (effective 3/1/2022)

Idaho provides a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.

- 63-day enrollment period, beginning on your applicant's birthday.
- Application must be signed (application signature date) within 63-day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Illinois Birthday Rule

Illinois provides a special Open Enrollment period for individuals between 65 and 75 years old who are currently enrolled in Medicare supplement plans.

- 45-day enrollment period, beginning on your applicant's birthday.
- Application must be signed (application signature date) within 45-day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- The new plan must be from the same underwriting company as the existing plan.
    - Note: if the existing plan's underwriting company is now closed, the birthday rule would not apply. The new application would need to be underwritten.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement cover age that includes plan description and effective dates, such as an ID card or Schedule Page.

Louisiana Birthday Rule

Louisiana provides a special Open Enrollment period for individuals who are currently enrolled in Medicare supplement plans.

- 63 day enrollment period, beginning on your applicant's birthday.
- Application must be signed (application signature date) within 63-day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- If the new plan is from the same underwriting company as the existing plan, the individual may purchase any Medicare Supplement policy offered in that state.
- If the new plan is not from the same underwriting company as the existing plan, the individual may purchase any standardized policy identified by a plan letter without an underwritten application, as long as the new plan benefits are less than or equal to the previous Medicare Supplement policy.
    - We need proof of current Medicare Supplement cover age that includes plan description and effective dates, such as an ID card or Schedule Page.

Missouri anniversary rule:

- 60-day enrollment period, beginning 30 days prior to your applicant's policy anniversary date.
- Your applicant must choose the same plan as their current plan (F to F, G to G).
- We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Nevada birthday rule:

Nevada provides a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.

- 60-day enrollment period, beginning on the first day of your applicant's birthday month.
- Application must be signed (application signature date) within 60-day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
    - We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Oregon birthday rule:

Oregon provides a special Open Enrollment period for individuals currently enrolled in Medicare supplement plans.

- 60-day enrollment period, beginning 30 days prior to your applicant's birthday.
- Application must be signed (application signature date) within 60-day Open Enrollment period.
- Effective date must fall on birthday or up to 90 days after birthday.
- Plan benefits must be of equal or lesser value to current plan.
- We need proof of current Medicare Supplement coverage that includes plan description and effective dates, such as an ID card or Schedule Page.

Key dates on the application

Choosing an effective date

All applications must contain a requested effective date, prior to the signature date. Although you may select an effective date up to 90 days past the signature date, we recommend effective dates be within 30 days of the signature date, with respect to Medicare eligibility. This increases the chance of successful first payment and minimizes the risk of application responses becoming outdated. The effective date is defaulted to application signature date unless a different date is chosen.

Signature and signature date

Applications must be signed by the primary insured (policy owner) and the spouse/domestic partner, if applicable. Power of Attorney signature is not acceptable.

For paper apps, signature dates must be:

- Prior to receipt of the application.
- Less than 30 days before we receive the application.
- prior to the effective date.

Initial draft date

Initial premium for Electronic Funds Transfer will either be drafted on the issue date or on the effective date of the policy. Although you can select either, we recommend selecting the effective date for first payment.

If the first attempt to draft the initial premium is not successful, we will make a second attempt to draft the initial premium. If the second attempt to draft the initial premium is not successful, the policy will be changed to quarterly direct bill. The policyholder will need to pay the premium in full before their policy is active. If we don't receive payment within 45 days, the policy will not be effective and a new application is required with payment to activate coverage.

If a draft is rejected, a letter will be sent to the policyholder and a copy mailed to the agent. The agent may also receive an email alert by signing up at Aflac Senior Agent Portal.

Know your bill date

If your applicant wants the bill date for their policy to be different than the Initial draft date, they may request a subsequent bill date on the application at the time of submission. If a future bill date is chosen greater than 15 days following the policy effective date, our system will draft the policyholder's account twice the first month to make sure the policy doesn't lapse before the next bill date.

The following are not available options for recurring bill dates: 29th, 30th or 31st of the month.

Application signatures

Whether taking an application in person or over the phone, it is important to read the Applicant's Statements and Agreements section in its entirety to the applicant.

Signatures and Power of Attorney

Applications must be signed by the primary insured (policy owner) and the spouse/domestic partner, if applicable.

Power of attorney signature is not permitted on underwritten Medicare Supplement applications, but is permissible on guaranteed issue and open enrollment applications. An application signed by power of attorney must follow the format of either "Mary Smith by John Smith, Attorney-in-Fact" or "John Smith, Attorney-in-Fact, for Mary Smith."

It is important to read the Applicant's Statements and Agreements section in its entirety to the applicant.

There are two signature methods to complete an application.

Telesales

In the event you cannot meet face-to-face with an applicant, you may use the Quote and Enroll process to take an application over the phone. Go to Aflac Senior Agent Portal and select Quote and Enroll from the Home page.

There are two ways to obtain a signature when taking an application over the phone.

Security Question Signature

1. Read the instructions aloud to the client and choose one of the security questions from the drop-down menu. Type the client's answer to the question.
2. Under the Security Question, there are two check boxes with statements to be read to the applicant. Check each box only after reading the statements and hearing the applicant respond "I agree."
3. After applicant signature is applied, the agent can sign the application by checking the box next to "I agree to terms and conditions" and clicking the "Apply agent signature" button.
4. Click on the "Submit application" button to complete and submit the application.

Note: If you choose to have the policy mailed to you rather than the applicant, the security question signature option is disabled.

Email Signature

1. To use the Email Signature option the agent must first check the box “I agree to terms and conditions” and click the button “Apply agent signature.”
2. Follow the on screen instructions to enter and verify the applicant’s email address.
3. Under the email address, there are two check boxes with statements to be read to the applicant. Check each box only after reading the statements and hearing the applicant respond “I agree.”
4. To use the Email Signature option the agent must first check the box “I agree to terms and conditions” and click the button “Apply agent signature.”
5. Next, click the “Send to applicants for signature” button.
6. The applicant will receive an email requesting they review and sign the application. Clicking “review and sign” will launch the application in a browser for electronic signature (powered by Adobe Acrobat Sign). The last four digits of the applicant’s Social Security Number will be the password to open the application documents.

Payment methods

EFT Payments:

- The EFT section of a paper application must be completed, signed and dated.
- If the owner of the bank account is someone other than your applicant, the bank account owner must sign where indicated on the application.
- All modes of premium may be drafted.

Social Security payments

- Social Security billing allows us to pull the premium payment via EFT on the 2nd, 3rd or 4th Wednesday of each month, which may allow the policyholder to align the payment with their Social Security payments.
- The current schedule may be attained from the SocialSecurity.gov website.
- If the applicant began receiving Social Security prior to May 1997, timing will occur as follows:
  - If the applicant was born on the 1st through the 10th of the month, select the second Wednesday of the month;
  - If the applicant was born on the 11th through the 20th of the month, select the third Wednesday of the month; and
  - If the applicant was born after the 20th of the month, select the fourth Wednesday of the month.

Requirement for direct bill payments:

- The Payment should be submitted at the same time as the application.
- If payment is not made at the time of application, the policy will be issued and an invoice will be sent to the policyholder.
- Direct bill is only available for quarterly, semi-annual and annual modes.
- No commissions payments and no claims are processed until the initial payment is received.
- Credit cards and debit cards of any kind are not accepted. This includes the Social Security Direct Express debit card.

Changing payment methods
If a policyholder wishes to change from direct bill to EFT payments or vice versa, you should work with the policyholder to submit a Billing Change Request.

Net billing
If there is a shortage on the initial payment, we'll send a bill notice to the applicant and the agent.

Medicare Supplement Underwriting

Underwriting Cycle
In most cases, the process is fully automated with a point-of-sale decision provided to the agent to share with the applicant. Where further review is required, underwriting is often completed within two business days. Where additional clarity is needed from an applicant, an underwriting analyst will reach out to the applicant within one business day of receipt of an in-good-order application.

- In the event a client does not qualify for a Medicare Supplement plan, the electronic application will inform the agent of such.
- Instructions on the paper application also provide direction on the applicant's eligibility.
- The Health History section may be used to clarify any health issues of the applicant, such as the use of a dual-purpose medication.

Underwriting Guidance
Medicare Supplement applications are subject to underwriting up until the time the policy is issued AND first premium is paid. If a declinable health condition is discovered between the time the application is taken and the time the policy is issued, the application will be declined.

- All applications are subject to a prescription drug database review and an MIB review.
- Paper applications must include all pages of the application, HIPAA form, replacement form (if applicable) and any state-required forms.
- All questions must be read as written and answers recorded as answered by the applicant to the best of their knowledge.
- All health questions must be answered up until a "Yes" answer disqualifies the applicant. Do not submit an application with a "Yes" response to a Health Question.
- Refer to the drug list located on Aflac Senior Agent Portal for any unacceptable medications.
- If the agent has additional relevant information, they may record it in the optional comments section of the application.
- Electronic applications are provided a color-coded classification at the end of the process, as follows:
    - Green: application is approved
    - Yellow: application is referred to an Underwriter to complete the underwriting process
    - Red: indicates the applicant is not eligible for coverage

Closed and declined applications

Reasons for closed applications

- If the application is pending more information, the application will be closed as incomplete if it is still pending after 15 days.
- If the document is incomplete or illegible, the application will be closed and cleared, and a complete application will need to be submitted.
- Incorrect documents were submitted.
- Applicant contact information is incorrect/missing and we haven't been able to contact the applicant.
- Anyone other than the applicant supplies the answers to the questions and/or signs the application.
- The applicant did not know they applied for insurance.
- The applicant does not consent to a prescription check, or does not complete a clarifying telephone interview.
    - Note: We'll attempt to call the applicant three times for a clarifying telephone interview. If we haven't been able to reach the applicant after those attempts, we'll send the applicant a letter letting them know they need to contact us within ten days of the date of the letter to schedule an interview. If the applicant does not contact us, we'll close their application and a new application will be required. Calls will come from **866-895-6487**.
- Anyone other than the applicant completes the clarifying telephone interview.
- During the telephone interview, we discover that the agent who signed the application did not speak with the applicant.
- If the application was submitted with a check from a third-party payor that has no family (spouse/partner, child, etc.) or business relationship (business owner, employee or retiree of the business).
- We receive the application at the home office more than 30 days after the applicant's signature date.
- Applicant is not a legal U.S. resident.
- Multiple options were selected within the non-forfeiture options of a paper Medicare Supplement application.
- Any application submitted with white-out on any page is automatically closed. When you resubmit, new signature dates are required.

VII. Policyholder Experience

Policyholder services

Sending documentation to policyholder services

We can't accept certain types of information via email. Mail or fax us the following types of information:

- Death certificates
- Bank information
- Anything that includes Protected Health Information (PHI)

Free-look period

The "Free-look period" is 30 days from the time the policyholder receives the policy. If they select the option for E-delivery, the 30-day Free-look period starts when we get an electronic delivery receipt. If mailed, an additional 15 days are allowed to account for mailing time.

A written request is needed to cancel within the Free-look period. The easiest and most accurate way to fulfil this requirement is to write "Cancel" on the policy and mail it back to us.

Withdrawing or canceling an application:

- If the application is in pending status, you or your applicant can call the New Business department at **866-951-0653** to withdraw the application.
- If the application status is already active, you or your policyholder can notify Policyholder Services to terminate the policy.
- Policyholder must send written request to cancel to: Fax **855-291-0553** or **P.O. Box 14863 Lexington, KY 40512**.

Changing benefit amounts

If your policyholder wants to decrease the benefit amount:

- Complete a new application for the total of the desired benefit amount; this application is not underwritten relative to the original application.
- Your applicant's current age will apply
- We'll cancel the existing policy and issue a new policy for the new benefit amount
- We'll refund any cash value from the cancelled policy to the policyholder
- The two-year contestability period restarts from the new policy effective date unless another contestability period is required by state law

If your policyholder wants to request a change to a non-tobacco status, a new application is required.

Mail new business applications: **Aflac, P.O. Box 14863, Lexington, KY, 40512**.

Changing dates and reinstatements

Changing policy effective date

A request to change the effective date must be submitted within 60 days of the application signature date:

- A written request from your policyholder stating a reason for the change must be sent to Policyholder Services fax **833-526-0523**.
- A new application is not required.

Please note: If an effective date is changed after 30 days, the policyholder's two-year contestability period restarts on the new effective date.

Changing a Payment Date

If your policyholder wants to change their premium payment date after their policy is active, they may contact our Policyholder Services department. The new payment date shouldn't be more than 15 days after the current bill date. If it is, our system will draft the policyholder's account twice the next month to make sure the policy doesn't lapse before the next bill date.

Policyholder Services phone: **833-504-0336**

Policy reinstatement

There will be no gap in coverage if payment is made within the state-allowed time frame.

If the policyholder does not make payment during the state-allowed time frame, a completed and signed reinstatement form is required for reinstatement consideration. Payment is required with reinstatement request.

A new application is required if payment is not made within 90 days of the paid to date.

Cancellations, refunds, and claims

Canceling a policy

If your policyholder wants to cancel their policy, you or your policyholder will need to send us a written request with your policyholder's name, policy number, signature and the date your policyholder wants cancellation to take effect.

- If your policyholder requests to cancel their policy, the agent of record will be sent a notification of cancel request. This may also be received via email alert by signing up at http://www.sellaflacseniorplans.com.

Premium refunds

Before we can issue a refund for premiums, any pending payment must clear. Refunds are always mailed in the form of a paper check. Even if your policyholder is set up for EFT, we are not able to deposit money back into a bank account.

- Allow 15 days for an EFT payment to clear (this is in place so last premium payment can clear first)

Policyholder claims

- All Medicare Supplement claims must be submitted through Medicare; we cannot process payment from balance due statements.
- Our liability is based on Medicare's approved and eligible charges. If Medicare has no coverage, then the secondary Medicare Supplement plan has no liability.
- If a policyholder does not agree with the way Medicare processed a claim, an appeal should be made directly to Medicare.
- Available Plans may require the policyholder to pay for Part B deductible or coinsurance. See the Outline of Coverage for details.
- Name changes must be made with Medicare before being changed on the Medicare Supplement policy. A mismatch will result in claims payment errors.
- After claim approval, allow 20 days for a paper check or money order to clear.

A policy will be rescinded for material misrepresentation pursuant to state law.

Online tools for policyholders

Aflac senior customer service portal

Aflac customer self-service is available at www.myaccount.aflac.com. From this Aflac login screen, customers must click the link for Aflac Medicare Supplement at the bottom of the page. This link leads to the senior customer service portal login page administered by Aetna. The login process will be enhanced in the future to allow single sign on from Aflac's login page directly to the senior customer service portal.

Once logged in, policyholders can:

- view policy details and claims
- request a duplicate policy
- update contact and bank information
- send department-specific requests

Logging into the portal

First time users need to click on the "Register Now" button to register their account. The sign-up process is quick and simple, but just in case technical assistance is required, we have a dedicated web assistance team that provides website related technical assistance. Policyholders may call a website technician at **1-800-587-5139** Monday through Friday, 8 AM to 5 PM CT.

Correspondence preference

To set correspondence preferences, policyholders may log in to the portal, click "My Notifications" on the left side of the screen, then click "Correspondence/Alert Preference" on the right side.

Policyholders are mailed EOBs on a quarterly basis if not opted out of paper delivery.

ID Cards

ID cards are available for Medicare Supplement policies only.

A temporary Medicare Supplement ID card is available to view, download, or print from our website.

VIII. Contact Information

Agent Services phone line: **833-504-0336**
Agent Contracting/Licensing fax: **855-571-3847**

New Business Customer Service Phone Line: **833-504-0336**
New Business fax: **877-380-2777**

Medicare Supplement Policyholder Service phone: **833-504-0336**
Medicare Supplement Policyholder Service fax: **855-291-0553**
Medicare Supplement Policyholder Service/Claims address: **P.O. Box 14863, Lexington, KY, 40512**

Aflac Medicare Supplement
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