Physicians Mutual®
Insurance for all of us.™

Physicians Life Insurance Company
Health Customer Service
PO Box 3313
Omaha, NE 68103-0313
1.800.228.9100

# MEDICARE SUPPLEMENT*

## HOUSEHOLD DISCOUNT QUESTIONNAIRE

**Policyowner Information**

Policy Number _____

Policyowner's Name _____
First Middle Initial Last

Address _____
Street City State ZIP

You may qualify for a premium discount based on a "YES" answer to both of the following questions:

| | YES | NO |
|---|---|---|
| Do you reside in the same household with any other person who owns a Medicare Supplement policy from Physicians Life Insurance Company or Physicians Mutual Insurance Company?..... | ☐ | ☐ |
| If yes, do you reside with less than four other Medicare-eligible adults?..... | ☐ | ☐ |

If you answered "YES" to both of the above questions, please list the full name of each resident owning a qualified Medicare Supplement policy:

| First Name | Middle Initial | Last Name |
|---|---|---|
| | | |
| | | |
| | | |

NOTE: If you do not continue to meet the above requirements to qualify for this discount after it has been added to your policy, the discount will be removed.

**Signature and Acknowledgment**

I understand the premium discount will not be added to my policy unless I have met the qualifications above. Upon approval, the discount will become effective on the monthly renewal date following receipt of this request.

X _____ _____
Policyowner's Signature Date

LA033-OH

*This form is only for use with Physicians Life Medicare Supplement plans issued in 2019 or later.