



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:

<u>First Name</u>	<u>Middle Initial</u>	<u>Last Name</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

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