P.O. Box 4884, Houston, TX 77210-4884

SPOUSAL COVERAGE DISCOUNT FORM
MEDICARE SUPPLEMENT PLANS

1) APPLICANT/INSURED

Insured/Applicant Name: ____
Last/First/MI

Date of Application: ________________________________

Policy Number if Applicable: _________________________

Social Security Number: _____________________________

2) APPLICANT

Applicant Name: ____
Last/First/MI

Date of Application: ________________________________

Social Security Number: _____________________________