

KEMPER SENIOR SOLUTIONS
**ACKNOWLEDGEMENT OF NONDUPLICATION
 PLEASE READ CAREFULLY BEFORE SIGNING**

 I, _____ certify that I
 (Agent's Name)
 have done the following:

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether duplicate coverage will occur with the issuance of this policy.
2. Reviewed the policies listed below and have found that duplications WILL or WILL NOT (circle one) occur with the issuance of the applied for policy.

(Form Number)	POLICY NUMBER#	TYPE OF POLICY
<u>COMPANY</u>	<u>POLICY NUMBER#</u>	<u>TYPE OF POLICY</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check One:

- a. _____ Duplication will not occur because the above-listed polic(y)(ies)# _____ will be replaced by the applied-for policy _____ (form number). Justification for the replacement is (explain benefit to consumer)

- b. _____ No health policies in force at this time.
- c. _____ Applicant has elected not to have the polic(y)(ies) reviewed.

 DATE AGENT/COMPANY REPRESENTATIVE

**NOTICE TO CONSUMERS
Age 65 and Older**

This Notice is required by the State Board of Insurance because of its concern that some consumers may buy unnecessary coverage or may replace their coverage needlessly. Buying too much coverage or replacing a policy may be a waste of your money.

1. PURCHASING MORE THAN ONE POLICY OF EACH OF THE FOLLOWING TYPES MAY BE UNNECESSARY AND COSTLY:

- SPECIFIED DISEASE (CANCER, STROKE, ETC.)
- HOSPITAL INDEMNITY
- BASIC HOSPITAL EXPENSE OR BASIC MEDICAL EXPENSE (THESE POLICIES ARE TYPIFIED BY A SCHEDULED BENEFIT PER ILLNESS)
- LONG TERM CARE

THE TEXAS STATE BOARD OF INSURANCE CANNOT SAY WHETHER YOU SHOULD OR SHOULD NOT PURCHASE ANY OR ALL OF THESE POLICY TYPES, THE DECISION IS YOURS ALONE AND SHOULD BE DETERMINED BY YOUR NEEDS AND CIRCUMSTANCES.

2. IF YOU HAVE MORE THAN ONE POLICY IN ANY OF THE ABOVE CATEGORIES, THE STATE BOARD OF INSURANCE SUGGESTS THAT YOU GET A SECOND OPINION FROM SOMEONE YOU TRUST AS TO WHETHER YOU NEED MORE THAN ONE OF THESE POLICIES.

3. IF YOU REPLACE EXISTING HEALTH INSURANCE POLICIES YOU MAY LOSE COVERAGE DURING A PERIOD OF TIME THAT NEW EXCLUSIONS, REDUCTIONS, LIMITATIONS, OR WAITING PERIODS MUST BE SERVED.

4. THE STATE BOARD OF INSURANCE STRONGLY URGES YOU TO ALLOW YOUR INSURANCE AGENT OR COMPANY TO REVIEW ALL YOUR CURRENT HEALTH POLICIES PRIOR TO REPLACING EXISTING HEALTH COVERAGE OR PURCHASING ADDITIONAL HEALTH COVERAGE.

I certify that my right to have all my existing health policies examined has been explained to me by the agent named above.

_____ I have been informed that the policy for which I am applying WILL or WILL NOT (circle one) result in duplicate coverage.

_____ I have chosen to waive my right to have my policies reviewed to determine if they unnecessarily duplicate each other.

I have read the attached notice. Dated this _____ day of _____, 20 _____.

 APPLICANT