Companion Life

Medicare Supplement Supply Requisition

Agent/Agency Name: _____ 10-Digit Agent #: _____

Shipping Address: _____ ☐ Check box if Residential Address ☐ Check box if New Address

City: _____ State: _____ Zip: _____

E-mail: _____ Phone: _____

State Availability: AR, GA, IL, IN, KY, NE, NV, OH, OK, PA, TN, TX, UT

Application Kits Include:

- Client Application
- Replacement Notices
- MIB Notice & Premium Receipt
- Fax Transmittal
- Outline of Coverage with Rates

State *(write state abbreviation)*	**Application Kits** *(select quantity)*	**Marketing Brochures** *(select quantity)*
	☐ 5 ☐ 10 ☐ 25	☐ 5 ☐ 10 ☐ 25
	☐ 5 ☐ 10 ☐ 25	☐ 5 ☐ 10 ☐ 25
	☐ 5 ☐ 10 ☐ 25	☐ 5 ☐ 10 ☐ 25

Additional Supplies Available
_____ Underwriting Guidelines
_____ Choosing a Medigap Policy Guide

Submit all orders via fax to (855) 370-2379

Need Overnight? Please provide the following information:

Vendor Name: ☐ FedEx ☐ UPS ☐ USPS ☐ Other _____

Account Number: _____

Available in quantities of 5, 10 or 25. Maximum quantity amount is 25; higher amount requires approval.