

Section 1 - Personal information			
Last name	First name	Middle initial	Social Security number - -
Street address	City	State	ZIP code
County	Primary phone ( )	Secondary phone ( )	
E-mail address	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Birth date / /	
Medicare claim number (as shown on your Medicare red, white and blue card)	Medicare Part A effective date / /	Medicare Part B effective date / /	

## Section 2 - Select a Priority Health Medicare Supplement Plan

**You must be enrolled in Medicare Part A and B**, you cannot have more than one Medicare Supplement Plan and cannot be enrolled in a Medicare Supplement and Medicare Advantage plan at the same time. Refer to the Outline of Coverage for the monthly cost of the plan and description of the plan. You must be a permanent resident of Michigan and physically reside there for at least six months of every year in order to be eligible for coverage and to pay the premium based on the county in which you reside. If you permanently move outside the State of Michigan or reside in Michigan for less than six months of every year, your premiums will change to the applicable Area 2 premium upon renewal. Coverage will only continue provided all other eligibility requirements continue to be satisfied. If you move outside of the United States or its territories, your Priority Health Medigap Plan will be terminated.

Please check the appropriate box for the plan you are applying for:  
 Plan A     Plan D     Plan F     Plan N

Your coverage will become effective on the first day of the month following receipt and approval of your completed application, or a date specified in your application. The date must be in the future. You will receive an I.D. card and a certificate confirming your effective date and premium.

If you would like coverage to begin at a later date, please indicate (the first day of a future month, month/day/year): \_\_\_\_\_

## Section 3 - Open enrollment period

<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you 65 or older and did you enroll in Medicare Part B within the last 6 months? If yes, what is the effective date of your Part B (month/day/year)? _____
--	---

## Section 4 - Guaranteed issue period

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you lost or are you losing other health coverage and received a notice from your prior health plan saying you are eligible for guaranteed issue of a Medicare Supplement plan, or that you had certain rights to buy such a plan? <b>Please include a copy of the termination notice with this application.</b>
--	--

**If you answer "yes" to any of the questions in Section 3 or Section 4, you are guaranteed acceptance into certain Priority Health Medicare Supplement Plans.**

**Section 5 - Please read the following statements and answer the questions**

Yes  No

Are you covered for medical assistance through the state Medicaid program?  
(Note to applicant: If you are participating in a "Spend-Down Program" and have not met your "Share of cost," please answer NO to this question.)

If yes;

Yes  No

a. Will Medicaid pay your premiums for this Medicare Supplement plan?

Yes  No

b. Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium?

Yes  No

Are you enrolled, or were you previously enrolled, in a Medicare Advantage plan?

a. If yes, indicate: Start date: \_\_\_\_\_ End date: \_\_\_\_\_

b. Reason for disenrollment (select one):

Plan is leaving Medicare

Plan is ending service in your area

You are moving out of the plan's service area

You replaced a Medigap policy for the first time and now wish to return

Company misled you or failed to follow the rules

Other (please specify): \_\_\_\_\_

Yes  No

Are you enrolled, or were you previously enrolled, in a Program of All-Inclusive Care for the Elderly (PACE)?

a. If yes, indicate: Start date: \_\_\_\_\_ End date: \_\_\_\_\_

b. Reason for disenrollment (please specify): \_\_\_\_\_

Yes  No

Are you enrolled, or were you previously enrolled, in an employer group or union health plan?

a. If yes, indicate: Start date: \_\_\_\_\_ End date: \_\_\_\_\_

b. Reason for disenrollment (please specify): \_\_\_\_\_

Yes  No

Are you enrolled, or were you previously enrolled, in a Medicare SELECT plan?

a. If yes, indicate: Start date: \_\_\_\_\_ End date: \_\_\_\_\_

b. Reason for disenrollment (select one):

You are moving out of the plan's service area

You replaced a Medigap policy for the first time and now wish to return

Other (please specify): \_\_\_\_\_

Yes  No

Are you enrolled, or were you previously enrolled, in a Medigap policy?

a. If yes, indicate: Start date: \_\_\_\_\_ End date: \_\_\_\_\_

b. Reason for disenrollment (select one):

Medigap plan ended through no fault of your own

Company misled you or failed to follow the rules

Other (please specify): \_\_\_\_\_

### Additional information

- You do not need more than one Medicare Supplement plan.
- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement plan.
- Your coverage will automatically be renewed each year as long as you pay your premiums.
- If, after purchasing this plan, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement plan will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan may be available. If it is no longer available, a substantially equivalent plan will be reinstated if requested within 90 days of losing Medicaid eligibility.
- To terminate your plan please notify Priority Health in writing 30 days prior to termination.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning Medicaid.

### Section 6 - Health information

If you are applying for coverage during your open enrollment or guaranteed issue period, please skip this section and proceed to section 7.

#### Have you sought medical treatment or consultation for any of these conditions in the past five years?

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. Cancer or leukemia (except basal cell skin cancer)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. Alzheimer disease or dementia?
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. Angina pectoris, coronary artery disease, congestive heart failure, stroke, transient ischemic attack (TIA), peripheral vascular disease, abnormal heart rhythm (including pacemaker implantation)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Chronic kidney disease including end stage renal disease (ESRD)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. Emphysema, chronic bronchitis, asthma requiring daily nebulizer or inhaler use, chronic obstructive pulmonary disease, tuberculosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. Cirrhosis of the liver or hepatitis B or C?
<input type="checkbox"/> Yes <input type="checkbox"/> No	7. Diabetes requiring insulin injections?
<input type="checkbox"/> Yes <input type="checkbox"/> No	8. Parkinson's disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, neuropathy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	9. Organ transplant, or have you been advised to have one?
<input type="checkbox"/> Yes <input type="checkbox"/> No	10. Alcoholism, substance abuse?
<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Bipolar illness, major depression, schizophrenia, psychosis?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Rheumatoid arthritis, connective tissue disorder, osteoporosis, severe bone or joint disease?

**continued >**

If you answered "yes" to any item in questions 1- 12, please explain below:

*(List date of service and treatment details – include physician visits, hospitalizations, surgeries, etc. Please include all medication prescribed.)*

Diagnosis \_\_\_\_\_

Treatment \_\_\_\_\_

Diagnosis \_\_\_\_\_

Treatment \_\_\_\_\_

**If the above space is not sufficient, reply on an additional sheet of paper; you must sign and date the additional page(s).**

Yes  No

13. Have you had a complete physical examination in the past 2 years?

If yes, provide dates and full details on lines provided below:

- a. What tests were performed?
- b. Were any tests found to be abnormal?
- c. Which ones?
- d. What diseases, disorders or medical conditions were diagnosed?
- e. What medication or treatment was prescribed or recommended?
- f. Please give the physician's name and address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Yes  No

14. Have you been advised to have more frequent mammograms, colonoscopies or other special tests?

If yes, provide dates and full details:

\_\_\_\_\_

Yes  No

15. Do you still drive?

If yes, how many moving violations have you had in the past 2 years? \_\_\_\_\_

If no, why did you stop? \_\_\_\_\_

Yes  No

16. Do you use handicapped parking?

If yes, why? \_\_\_\_\_

Yes  No

17. Do you require assistance (by professionals or family members) with the activities of daily living?

If yes, why? \_\_\_\_\_

Yes  No

18. Are you currently disabled, hospitalized or confined to a facility such as a skilled nursing facility?

If yes, why? \_\_\_\_\_

<input type="checkbox"/> Yes <input type="checkbox"/> No	19. Do you use a wheelchair, a walker, or other such device? If yes, why? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	20. What is your height and weight: Height _____ Weight _____ a. Has your weight changed in the past year? _____ b. Amount of change? _____ c. Gained or lost? _____ d. Reason for change: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	21. Have you been advised to change or supplement your diet? If yes, details: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	22. Have you been advised to decrease or discontinue your consumption of alcohol?
<input type="checkbox"/> Yes <input type="checkbox"/> No	23. Are you able to engage in regular physical activity? If yes, describe: _____ If no, why not?: _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	24. Do you use any tobacco products, or have you ever used any tobacco products? a. If you are a former tobacco user, when did you stop? _____ b. Why? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	25. List all medications you are currently taking: a. Prescription: _____ b. Non-prescription: _____

**If the above space is not sufficient, reply on an additional sheet of paper; you must sign and date the additional page(s).**

**Section 7 - Payment information**

- Receive a bill monthly and pay the plan directly by mail.
- Electronic funds transfer (EFT) from your bank account each month.

On the first day of every month, the checking or savings account you designate will be debited for the amount of your premium. You will receive a billing statement each month approximately ten (10) days before your account will be debited.

If you have questions about the automatic bill payment plan, please contact customer service at 800 852-9780. (There will be a \$50 charge for the first transfer returned. A second non-sufficient funds (NSF) return will result in termination of coverage.)

Name of financial institution	Account type <input type="checkbox"/> checking <input type="checkbox"/> savings
ABA/routing number (9 digits on the bottom of check for a checking account) or attach a copy of a voided check.	Account number
Print name	
Account holder's signature	Date

**Section 8 - Important authorization and verification information. Please read, sign and date where indicated.**

My signature below indicates that I have read and understand the contents of this application.

I declare that the answers on this application are complete and true to the best of my knowledge and belief, and are the basis for issuing coverage. I understand that the application and amendments become a part of the contract and that if the answers are incomplete, incorrect or untrue, Priority Health may have the right to rescind my coverage, adjust my premium, or reduce my benefits.

Any person who knowingly and with intent to defraud any health plan company or other person files an application or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.

I understand the coverage under the plan I am applying for will not take effect until issued by Priority Health. Priority Health requires proper handling of personal health information for its members. Details of Priority Health's confidentiality policies and procedures are available upon request.

Yes  No I have received a copy of the *Priority Health Medicare Supplement Plans Outline of Coverage*.

Yes  No I have received a copy of *Choosing a Medigap Policy*.

I understand that the following parties may need to collect information on me in regard to the proposed coverage: Priority Health and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose.

The following information may be disclosed to or by Priority Health: any and all individually identifiable health information, including but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results.

Those parties that may need to collect information may disclose information to the following: other insurers to which I have applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities, healthcare clearing houses; or persons who perform business, professional, or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information to making eligibility, underwriting and risk rating determinations. Unless revoked earlier, this authorization will be valid for thirty (30) months after the date it is signed.

I understand that I can revoke this authorization at any time by giving written notice to Priority Health at 1231 E Beltline, NE, MS 1175, Grand Rapids, MI 49525. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment.

I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Applicant printed name

Applicant signature

Date

Applicant's street address

City

State

ZIP code

**continued >**

If you are the authorized personal representative, you must provide the following information:

Personal representative's printed name

Personal representative's signature

Date

Street address

City

State

ZIP code

Phone

Relationship to applicant

**Section 9 - Agency form (to be completed by insurance agent)**

Yes  No Have you sold any other policies to this individual that are still in force?  
If yes, please submit documentation with application.

Yes  No Have you sold any policies to this individual in the last five (5) years that are not still in force?  
If yes, please submit documentation with application.

Please list any other health insurance policies you have personally sold to the applicant that are still in force. If none, please write none. Also, list any policies you sold to the applicant in the past five (5) years that are no longer in force.

In force  
 Yes  No Policy description

In force  
 Yes  No Policy description

In force  
 Yes  No Policy description

Yes  No I asked the applicant all the questions in this application and the answers are recorded as given to me.

Signed at

Date

Agency name

Field Market Organization (FMO) / General Agency (GA) name (if applicable)

Street address

City

State

ZIP code

E-mail address

Primary phone  
( )

Fax  
( )

Writing agent printed name

Agent number

Writing agent signature

Date

**Applications can be submitted online at [prioritymedicare.com](http://prioritymedicare.com) or mailed.**

Mail all required forms using either the enclosed business reply envelope, or address to:

Priority Health  
Enrollment Department, MS1175  
1231 E. Beltline Ave. NE  
Grand Rapids, MI 49525

**Internal use only**

Application acknowledged by

Date

# Notice to applicant regarding replacement of Medicare Supplement coverage



Priority Health, 1231 E. Beltline NE, Grand Rapids, MI 49525

## **SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

According to your application or the information you have furnished, you intend to drop or otherwise terminate existing Medicare Supplement coverage or a Medicare Advantage plan and replace it with a certificate to be issued by Priority Health. Your new certificate provides thirty (30) days within which you may decide, without cost, whether you desire to keep the certificate.

You should review this new coverage carefully, comparing it with all disability and other health coverage you now have. You should terminate your present coverage only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

## **Statement to applicant by Priority Health, agent, broker or other representative:**

I have reviewed your current medical or health coverage as disclosed to me. The replacement of coverage involved in this transaction does not duplicate your existing Medicare Supplement, or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan, to the best of my knowledge. The replacement plan is being purchased for the following reasons (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D
- Disenrollment from a Medicare Advantage plan  
**Please explain reason for disenrollment** \_\_\_\_\_
- Other (please specify) \_\_\_\_\_

If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded.

**Do not cancel your present policy until you have received your new certificate and are sure that you want to keep it.**

**The “Notice to Applicant” was delivered to me on (date): \_\_\_\_\_**

Signature of Agent, broker or other representative (signature not required for direct response sales)		Date	
Printed name of agent, broker, or other representative		Agency number	
Agent's street address	City	State	ZIP code
Applicant's signature		Date	
Printed name of applicant			
Applicant's street address	City	State	ZIP code
Policy, certification or contract number being replaced			