

Medicare Supplement Plan Application



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 can't 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 also be a permanent resident of Michigan and physically reside there seven months out of every year.

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)? _____
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Section 4 - Guaranteed issue period

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

Questions about Medicaid

<input type="checkbox"/> Yes <input type="checkbox"/> 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.)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, a) Will Medicaid pay your premiums for this Medicare Supplement policy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, b) Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?

Questions about Medicare replacement coverage

	a) If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. Start _____ End _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?
<input type="checkbox"/> Yes <input type="checkbox"/> No	c) Was this your first time in this type of Medicare plan?
<input type="checkbox"/> Yes <input type="checkbox"/> No	d) Did you drop a Medicare Supplement policy to enroll in this Medicare Supplement plan?

Questions about Medicare Supplement, Medicare Select

<input type="checkbox"/> Yes <input type="checkbox"/> No	a) Do you have another Medicare Supplement policy in force? b) If yes, with what company? _____ What plan do you have? _____
<input type="checkbox"/> Yes <input type="checkbox"/> No	c) If yes, do you intend to replace your current Medicare Supplement policy with this plan?

Questions about any other health insurance

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) a) If yes, with what company? _____ What kind of policy do you have? _____ b) What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank. Start _____ End _____
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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.

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- 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 2 years? If the answer is “Yes” to any of the following questions (1-9), you are not eligible for coverage:

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Cancer (except non-melanoma skin cancer) or leukemia? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Alzheimer’s disease, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy, Parkinson’s disease or senile dementia? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Angina pectoris, stroke, congestive heart failure (CHF), coronary artery disease (CAD), or vascular disease? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Chronic kidney disease or disorder including end stage renal disease (ESRD) or dialysis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, or tuberculosis? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. Cirrhosis of the liver or hepatitis B or C? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Diabetes or hemophilia? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Organ transplant to include heart, liver, kidney, pancreas, lung, or bone marrow? |

Your response to the following questions may influence your eligibility and/or monthly premium. Once your application is processed, we will advise you of your monthly premium for the plan you choose.

Read the following questions carefully. If you answer “yes” to questions 10 - 12, please provide additional information in the section below.

- | | |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Are you currently disabled, hospitalized or confined to a facility such as a skilled nursing facility? |
|--|--|

<input type="checkbox"/> Yes <input type="checkbox"/> No	11. Has a physician advised you to have treatment, medical tests, surgery or therapy for any condition in the next 12 months (including hospitalization or confinement to a facility)?
<input type="checkbox"/> Yes <input type="checkbox"/> No	12. Have you been hospitalized or confined to any facility more than once in the past 12 months?
<input type="checkbox"/> Yes <input type="checkbox"/> No	13. Have you used tobacco products in the last 12 months?
	14. Please provide the following: Height _____ Weight _____

If you answered "yes" to any item in questions 10-12, please explain below:

Diagnosis _____

Treatment _____

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

Diagnosis _____

Treatment _____

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

If the above space is not sufficient, please include an additional sheet of paper, and sign and date the page.

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)	Account number
Print name	
Account holder's signature	Date

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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 insurance 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 insurance company or other person files an application for insurance 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 insurance 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
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)			
<input type="checkbox"/> Yes <input type="checkbox"/> No		Have you sold any other policies to this individual which are still in force? If yes, please submit documentation with application.	
<input type="checkbox"/> Yes <input type="checkbox"/> 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 <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy description	
In force <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy description	
In force <input type="checkbox"/> Yes <input type="checkbox"/> No		Policy description	
<input type="checkbox"/> Yes <input type="checkbox"/> 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			Tax ID number
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 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
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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			