Medicare SUPPLEMENT℠
BROUGHT TO YOU BY HEALTH ALLIANCE

301 S. Vine St.
Urbana, IL 61801-3347
1-877-933-0028
TTY 711

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Member Assigned #:

Effective Date:

SECTION 1: APPLICANT(S)

Applicant A	**Applicant B**
Name *(Last, First, Middle Initial)*	Name *(Last, First, Middle Initial)*
Medicare Number *(required)* ___ ___ ___–___ ___–___ ___ ___ ___ ___	Medicare Number *(required)* ___ ___ ___–___ ___–___ ___ ___ ___ ___
Hospital Insurance (Part A) Entitlement Date *(mm/dd/yyyy)*	Hospital Insurance (Part A) Entitlement Date *(mm/dd/yyyy)*
Hospital Insurance (Part B) Entitlement Date *(mm/dd/yyyy)*	Hospital Insurance (Part B) Entitlement Date *(mm/dd/yyyy)*
Social Security Number ___ ___ ___–___ ___–___ ___ ___ ___	Social Security Number ___ ___ ___–___ ___–___ ___ ___ ___
Permanent Address or P.O. Box including City, State and ZIP Code	Permanent Address or P.O. Box including City, State and ZIP Code
Mailing Address including City, State and ZIP Code *(if different from above)*	Mailing Address including City, State and ZIP Code *(if different from above)*
Home Telephone	Home Telephone
Sex: ❑ Male ❑ Female | Date of Birth	Sex: ❑ Male ❑ Female | Date of Birth
Marital Status: ❑ Married ❑ Single ❑ Widowed	Marital Status: ❑ Married ❑ Single ❑ Widowed

SECTION 2: PLAN SELECTION

Select One: ❑ Plan A ❑ Plan C ❑ Plan F ❑ Plan N	Select One: ❑ Plan A ❑ Plan C ❑ Plan F ❑ Plan N

SECTION 3: CONSUMER PROTECTION INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge.

	Yes	No
1.		
a. Did you turn age 65 in the last six months?	❑	❑
b. Did you enroll in Medicare Part B in the last six months?	❑	❑
c. If Yes, what is the effective date? _____		
2. 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:		
a. Will Medicaid pay your premiums for this Medicare Supplement policy?	❑	❑
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	❑	❑
3. 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. (If you are still covered under this plan, leave "End Date" blank)		
Start Date: _____		
End Date: _____		
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If Yes, read and fill out * section on next page)	❑	❑
b. Was this your first time in this type of Medicare plan?	❑	❑
c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	❑	❑
4. Do you have another Medicare Supplement policy in force?	❑	❑
a. If Yes, with what company and what plan do you have? _____ _____		
b. If Yes, do you intend to replace your current Medicare Supplement policy with this policy? (If Yes, read and fill out * section on next page)	❑	❑

Please answer all questions to the best of your knowledge.

	Yes	No
1.		
a. Did you turn age 65 in the last six months?	❑	❑
b. Did you enroll in Medicare Part B in the last six months?	❑	❑
c. If Yes, what is the effective date? _____		
2. 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:		
a. Will Medicaid pay your premiums for this Medicare Supplement policy?	❑	❑
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	❑	❑
3. 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. (If you are still covered under this plan, leave "End Date" blank)		
Start Date: _____		
End Date: _____		
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? (If Yes, read and fill out * section on next page)	❑	❑
b. Was this your first time in this type of Medicare plan?	❑	❑
c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	❑	❑
4. Do you have another Medicare Supplement policy in force?	❑	❑
a. If Yes, with what company and what plan do you have? _____ _____		
b. If Yes, do you intend to replace your current Medicare Supplement policy with this policy? (If Yes, read and fill out * section on next page)	❑	❑

Yes No 5. Have you had coverage under any other health insurance within the past 64 days? (For example, an employer, union or individual plan) ❑ ❑ a. If Yes, with what company, and what kind of policy? _____ _____ b. What are your dates of coverage under the other policy? (If you are still covered under this policy, leave "End Date" blank.) Start Date: _____ End Date: _____	Yes No 5. Have you had coverage under any other health insurance within the past 64 days? (For example, an employer, union or individual plan) ❑ ❑ a. If Yes, with what company, and what kind of policy? _____ _____ b. What are your dates of coverage under the other policy? (If you are still covered under this policy, leave "End Date" blank.) Start Date: _____ End Date: _____
I certify that (1) the statements and answers above are true, complete and correct to the best of my knowledge and belief. (2) I have read and understand the statements in this document regarding Medicare Supplement coverage. (3) I have received an Outline of Coverage and the *Guide to Health Insurance for People With Medicare*. (4) If applicable, I have read and understand the section called "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."	I certify that (1) the statements and answers above are true, complete and correct to the best of my knowledge and belief. (2) I have read and understand the statements in this document regarding Medicare Supplement coverage. (3) I have received an Outline of Coverage and the *Guide to Health Insurance for People With Medicare*. (4) If applicable, I have read and understand the section called "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."
Applicant Signature: _____ Date: _____	Applicant Signature: _____ Date: _____
Legal Guardian Signature: _____ *(must provide documentation)* Date: _____	Legal Guardian Signature: _____ *(must provide documentation)* Date: _____

***Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage**

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

According to the information furnished in your application you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Health Alliance Medical Plans, Inc. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement or, if applicable, policy will not duplicate your existing Medicare Supplement coverage because you intend to terminate your existing Medicare Supplement or leave your Medicare Advantage Plan. The replacement policy is being purchased for the following reason (Check one and explain below):

	Additional benefits.		My plan has outpatient prescription drug coverage, and I am enrolling in Medicare Part D for disenrollment.
	No change in benefits, but lower premiums.		Fewer benefits and lower premiums.
	Disenrollment from a Medicare Advantage Plan.		Other

Please specify and/or explain:

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. (Note: If the insurer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing, preexisting limitations, please skip to statement below.)

2. Section 363(7)(b) of the Illinois Insurance Code [215 ILCS 5/363(7)(b)] provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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

To Be Completed By Insurance Producer:

1. List any policies personally sold to the applicant that are still in force. Indicate if policy is to be replaced. Name of Company _____ Type of Coverage _____ To be replaced? ❑ Yes ❑ No	1. List any policies personally sold to the applicant that are still in force. Indicate if policy is to be replaced. Name of Company _____ Type of Coverage _____ To be replaced? ❑ Yes ❑ No
2. List policies personally sold to the applicant in the past five (5) years that are no longer in force. Name of Company _____ Type of Coverage _____ Policy Number _____	2. List policies personally sold to the applicant in the past five (5) years that are no longer in force. Name of Company _____ Type of Coverage _____ Policy Number _____

To the best of my knowledge, replacement ❑ is / ❑ is not involved in the purchase. I certify that I have reviewed the current health insurance coverage of the applicant and find that additional coverage, of the type and amount applied for, is appropriate for the applicant's needs.

Insurance Producer Signature _____

Printed Full Name of Insurance Producer _____

Important Information Regarding Medicare Supplement Coverage

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

An individual age 65 and older may enroll in the Medicare Supplement policy at any time during the year. Disabled individuals under age 65 who are enrolled in Medicare Part B may enroll in the Medicare Supplement policy during their Open Enrollment period and during the Annual Election period.

If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. The benefits and premiums under your Medicare Supplement policy 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days after losing your employer or union-based group health plan.

If you are under 65 and on Medicare, but you declined a Medicare Supplement policy because you were still covered under an employer group health plan, you will have a 63-day Open Enrollment period if the employer plan terminates or ceases to provide health benefits that supplement Medicare. If you are currently enrolled in a Medicare Advantage plan or have a Medicare Supplement policy and the insurance company goes out of business, withdraws from the market, or misrepresented the product you purchased, you will be eligible for a 63-day Open Enrollment period.

Counseling services are available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the State Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low Income Medicare Beneficiary (SLMB). For information on Medicaid eligibility, call 1-800-252-8635. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

I hereby apply for membership and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date specified on my Medicare Supplement Policy Schedule. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.

I hereby authorize and direct Health Alliance Medical Plans, Inc., (Health Alliance) and/or the plan administrator to obtain all information and medical records from any health care provider that, either before or after acceptance of my application and enrollment in the plan, advised, treated, attended or rendered service to me, or that has in their possession any information or records with respect to advice, treatment or services. This authorization is limited only to such personal information and medical records as are necessary for Health Alliance and/or the plan administrator to determine the acceptability of this application; post-enrollment claims review; treatment; coordination of care; quality improvement; measurement, including reporting activities, surveys and accreditation; medical management and reporting activities; utilization review; complaints and appeals and requests for services or benefits under the plan, or for establishment and maintenance of proper records. A copy of this authorization and release shall be as valid as the original and will remain in effect as long as I am enrolled in the plan or until rescinded by me in writing.

I authorize Health Alliance, at its option, to pay providers directly for services rendered. In addition, I hereby authorize the Centers for Medicare & Medicaid Services, or its duly appointed Part A or Part B carriers or intermediaries, to release to Health Alliance information they may require in the processing of my supplement insurance or other insurance coverage I may have through them. This information may include Explanations of Medical Benefits (EOMBs), “deduct-not-met” or denial letters, Part B billing forms and date of entitlement to Part B of Medicare. I further authorize ongoing release of this information to Health Alliance for as long as I am enrolled under the supplement coverage. I understand I may revoke this authorization for release of Title XVIII (Medicare) information for supplement insurance coverage at any time by notifying Health Alliance in writing. I understand that if I do rescind my authorization for the release of Title XVIII information, I will need to fill out claim forms, and some records could be released before the rescission takes effect.