

Individual Medicare Supplement Insurance

Application Form

INSTRUCTIONS

- This is an application for Medicare Supplement Insurance **underwritten by Group Health Incorporated (“GHI”)**, an EmblemHealth company. It may be used to apply for new enrollment, or change in type of coverage. This application may be used to apply for one of our EmblemHealth Medicare Supplement Insurance Plans.
- **GHI, an EmblemHealth company, cannot sell you a Medicare Supplement Insurance Plan if:**
 - **you already have a Medicare Supplement policy in force and you do not desire to replace the existing policy; or**
 - **the Medicare Supplement policy would duplicate benefits to which you are entitled under a Medicare Advantage plan.**
- **Return your completed application.** If you do not send payment with your application, we will send you an invoice after the application is processed and your eligibility has been confirmed. If you are submitting premium payment with this application, the policy will become effective once we determine that you are eligible for a Medicare supplement insurance policy. We will provide coverage for benefits described in the policy, contingent upon insurability. We will determine if you are insurable no later than the date of completion of all parts of the application and the premium has been paid, unless you request a later effective date. If you request a later effective date, you understand that you may be waiving certain rights and guarantees under this conditional receipt. If the policy is not issued within this time, the application will be deemed rejected and all premiums will be refunded.
 - **If you are applying as a current EmblemHealth member who is switching to an EmblemHealth Medicare Supplement plan:** Coverage will be effective on the termination date of your previous EmblemHealth plan so you will not have a break in coverage. You must apply within 60 days of the termination date of your previous coverage in order for your Medicare Supplement plan to take effect on the termination date. You may apply after the 60-day period, but in that case you may have a break in coverage.
- **All applicants must:**
 - a. Be residents of New York State.
 - b. Complete the application statement, sign and date the application where indicated.
 - c. Check the appropriate boxes for the coverage you are applying for.
 - d. Return completed application to:
 - EmblemHealth
 - P.O. Box 2820
 - New York, NY 10016-2820

If you will be eligible for Medicare by reason of age only, we cannot accept your application more than 90 days prior to the month of your 65th birthday.



PRINT IN INK

INDIVIDUAL APPLICATION FOR PERSONS ELIGIBLE FOR MEDICARE

Social Security No.			
1. <input type="checkbox"/> I am/was an EmblemHealth member. My EmblemHealth ID number is: _____ If you are not an EmblemHealth member, go to question 2.			
2. Applicant's Last Name		First Name	Middle Name
3. Home Address			County
City	State	ZIP Code	Care of
4. <input type="checkbox"/> Male <input type="checkbox"/> Female			
5. Date of Birth (Month/Day/Year):			
I understand that the phone numbers I provided on this application may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.			
6. Telephone No.:			
7. Email Address:		Date you became eligible for Medicare:	

You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing coverage and decide if you need multiple coverage. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy may be suspended, if requested, 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 policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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 reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Counseling services may be 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).

Please respond to questions 8 through 14 below to the best of your knowledge or belief: (Please mark Yes or No below with an "X")

8. (1) Did you turn age 65 in the last 6 months? Yes No

(2) Did you enroll in Medicare Part B in the last 6 months? Yes No
If yes, what is the effective date? _____

9. 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.) Yes No

(1) Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

(2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
 Yes No

10. (1) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave END DATE blank. START DATE _____ END DATE _____

(2) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No

(3) Was this your first time in this type of Medicare Advantage plan? Yes No

(4) Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan? Yes No

11. (1) Do you have another Medicare supplement or Medicare Select policy or certificate in force? Yes No

(2) If so, with what company, and what plan do you have? _____

(3) If so, do you intend to replace your current Medicare supplement or Medicare Select policy or certificate with this policy or certificate? Yes No

12. Have you had coverage under any other health insurance policy or certificate within the past 63 days? (For example, an employer, union, or individual plan.) Yes No

(1) If so, with what company, and what kind of policy?

(2) What are your dates of coverage under the other policy? (If you are still covered under the policy, leave END DATE blank.) START DATE _____ END DATE _____

(3) Do you intend to replace the coverage(s) you identify in this item 12 above with this Medicare supplement policy or certificate? Yes No

13. I am applying for the following EmblemHealth Medicare Supplement Insurance Plan: (Check the appropriate box.)

Plan A **Plan B** **Plan C** **Plan F** **Plan F+** See enclosed disclosure statement for the applicable rates.

Proposed Effective Date (Month/Day/Year): _____

Coverage is effective as of the 1st of the month following approval of your completed application. To ensure continuation of coverage, you can request an initial effective date other than the 1st of the month. The effective date must be within 90-days of application signature. After the initial effective date, your policy will move to a 1st of the month anniversary date.

Coverage is contingent upon our receipt of the premium. Plan F+ is a high deductible plan.

14. If you are replacing any in force coverage with this Medicare supplement policy or certificate, what is the reason you are replacing the coverage:

- | | |
|---|--|
| <input type="checkbox"/> Additional benefits | <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D. |
| <input type="checkbox"/> No change in benefits, but lower premiums. | <input type="checkbox"/> Disenrollment from a Medicare Advantage plan due to: _____ |
| <input type="checkbox"/> Fewer benefits and lower premiums. | _____ |
| <input type="checkbox"/> Other: (please explain) _____ | _____ |

The EmblemHealth Medicare Supplement Insurance Plans impose a pre-existing condition limitation. If you have a pre-existing condition, that condition generally is not covered for the first six months after the effective date of coverage under the EmblemHealth Medicare Supplement Insurance Plan. A pre-existing condition is any condition for which medical advice was given or treatment was recommended by or received from a physician, within six months prior to the effective date of coverage.

In applying the pre-existing condition limitation, GHI, an EmblemHealth company, will credit the time you were previously covered under creditable coverage if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new coverage. GHI, an EmblemHealth company, will reduce the period of the pre-existing condition limitation by the aggregate of the period of creditable coverage without regard to the specific benefits covered during the period. Creditable coverage includes: a group health plan; health insurance coverage; Medicare; Medicare supplement insurance; Medicare select coverage; Medicare Advantage plan; Medicaid; CHAMPUS; TRICARE; medical programs of the Indian Health Service or a tribal organization; a State health benefits risk pool; Federal Employees Health Benefits Program; a public health plan; and a health benefit plan under Section 5(e) of the Peace Corp Act.

I represent and understand that:

- A.** The contract applied for will have the Effective Date specified on the contract schedule page. On that date, my existing Medicare Supplement or Medicare Advantage coverage, if any, shall be cancelled.
- B.** All statements and answers in this application are true upon knowledge and belief. This application will be made part of the contract which will become effective on the date specified on the contract schedule page.

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR THE TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a criminal penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Name: _____

Signature: _____

Title: _____

Date: _____

To be completed by insurance agent only

Have you sold any other any other accident and health insurance plans to the applicant that is still in force?

Yes No

Have you sold any other accident and health insurance plan policies to the applicant in the last five (5) years that are not still in force? Yes No

If yes, please list any other health plan 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.

If the applicant is replacing health coverage with Medicare supplement insurance coverage, please submit a completed EmblemHealth NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT along with this application.

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.

Agency Name: _____

GA Name: _____

GA Broker Number: _____

Selling Agent Name: _____

Selling Agent Number: _____

Agent Address: _____

Agent Email: _____

Agent Primary Phone: _____

Agent Fax: _____

Agent Signature: _____

(For EmblemHealth Office Use Only)

Date Application Issued
Date Application Received
Date Application Processed
Date, Contract and Copy of Application Sent
Type of Plan
Group Number
Category Number
Effective Date

Current EmblemHealth Member

