MercyCare

Medicare Select Application

Underwritten and administered by MercyCare HMO, Inc

MercyCare Health Plans™

APPLICANT INFORMATION

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Date of Birth (mm/dd/yyyy) _____

Home Address _____

City _____ State _____ Zip Code _____ County _____

Telephone Number _____ Effective Date (mm/dd/yyyy) _____

Do you live at the above address year around? ☐ YES ☐ NO If No, Explain: _____

_____

Primary Care Physician: _____

MercyCare Senior is required to ask you and notify your primary health care provider if you have an advance directive (living will or durable power of attorney for health care)? ☐ YES ☐ NO

List the name, address, phone number and relationship of someone we can contact if we are unable to reach you:

_____

How did you hear about MercyCare Senior? _____

UNDERWRITING QUESTIONS

DO NOT ANSWER QUESTIONS 1 AND 2 BELOW IF (1) You are currently insured by MercyCare, are losing eligibility, and apply for this plan at least 30 days prior to coverage termination or (2) You apply for this plan during your six month open enrollment period, which begins when (A) you enroll for Medicare Part B for the first time (the effective date of Medicare Part B begins your enrollment period) or (b) you turn age 65 if you are already enrolled in Medicare Part B or (3) You are eligible for guaranteed issue. Guaranteed issue applies when you lose or terminate health coverage under certain circumstances, providing you apply within 63 days of the termination date of your prior health plan. You must provide a copy of the termination notice you received from your prior plan along with your application. This notice must verify the circumstances of your prior plan's termination and also describe your right to guaranteed issue of the Medicare supplement insurance. See the Outline of Coverage for more information as to when guaranteed issue applies.

ANSWER THE FOLLOWING TWO QUESTIONS IF you have been enrolled in Medicare Part B for longer than six months and do not meet the qualifications under the above information.

1. Are you currently bedridden, hospitalized, institutionalized, or using a life support ventilator?
   ☐ NO ☐ YES
2. At this time, due to a mental or physical disability or incapacity, do you have a person or institution authorized to legally act on your behalf and conduct your daily personal business transactions? ☐ NO
   ☐ YES - If yes, please explain in more detail: _____

   _____

OTHER INSURANCE

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 insurance 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. [Please mark Yes or No below with an "X"]

TO THE BEST OF YOUR KNOWLEDGE:

1. a. Did you turn age 65 in the last 6 months? ☐ YES ☐ NO
   b. Did you enroll in Medicare Part B in the last 6 months? ☐ YES ☐ NO
   c. If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program? ☐ YES ☐ NO

   [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? ☐ YES ☐ NO
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ YES ☐ NO
3. 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 health maintenance organization or preferred provider organization), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____ /_____/_____ END _____/_____/_____
   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ YES ☐ NO
   c. Was this your first time in this type of Medicare plan? ☐ YES ☐ NO
   d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO
4. a. Do you have another Medicare supplement policy in force? ☐ YES ☐ NO
   b. If so, with what company, and what plan do you have?

      _____
   c. If so, do you intend to replace your current Medicare supplement policy with this policy?
      ☐ YES ☐ NO
5. Have you had coverage under any other health insurance within the past 63 days? (For example an employer, union, or individual plan) ☐ YES ☐ NO
   a. If so, with what company and what kind of policy?

      _____
   b. What are your dates of coverage under the other policy?
      START _____/_____/_____ END _____/_____/_____
      (If you are still covered under this plan, leave "END" blank.)

If you are enrolled and currently covered under state Medicaid program, you are **NOT** eligible to enroll in MercyCare Health Plans unless you are covered under Medicaid as a Specified Low-Income Medicare Beneficiary.

Medicaid is a public aid program for low-income individuals. It is <u>not</u> the same as Medicare.

PAYMENT AND EFFECTIVE DATE INFORMATION

At least two months premium must be sent with your application. Premium paid $_____

Your premium will then be billed to you monthly. You may pre-pay up to twelve (12) months in advance.

You may also have the premium automatically withdrawn from either your savings account or your checking account. The payment would be withdrawn from your account on the tenth day of each month. If you choose to participate in the automatic withdrawal program (ACH Debits) you will not receive monthly statements from MercyCare. However, you will still receive at least 30 days notice of any increase in premiums.

Please check the mode of payment you are requesting below.

☐ **Monthly Bill** ☐ **ACH Debits/Automatic Withdrawal**

If you checked the box for ACH Debits/Automatic Withdrawal please fill out the **Authorization Agreement for Direct Payments (ACH Debits)** on page 3. Payments are taken out approximately the **tenth** of every month.

AUTHORIZATION AGREEMENT FOR DIRECT PAYMENT (ACH DEBITS)

I (we) hereby authorize **MercyCare HMO, Inc.** to initiate debit entries to my (our):

☐ Checking Account ☐ Savings Account **(Select one)**

Indicated at the depository financial institution named below, hereafter-called DEPOSITORY, and to debit the same to such account. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with the provisions of U.S. law.

Additionally, I (we) hereby authorize **MercyCare HMO, Inc.** to initiate credit entries to my (our) account and the DEPOSITORY to credit the same to such account, in the case where the incorrect amount has been debited to such account in error.

Depository Name _____ Branch _____

City _____ State _____ Zip _____

Routing Number**_____ Account Number**_____

This authorization is to remain in full force and effect until MercyCare HMO, Inc. has received written notification from me (or either of us) of its termination in such time and in such manner as to afford MercyCare HMO, Inc. and DEPOSITORY a reasonable opportunity to act on it.

Name(s) _____

(Please Print)

MercyCare Account Number(s) 00000___ _____ _____.

Signature _____ Date _____

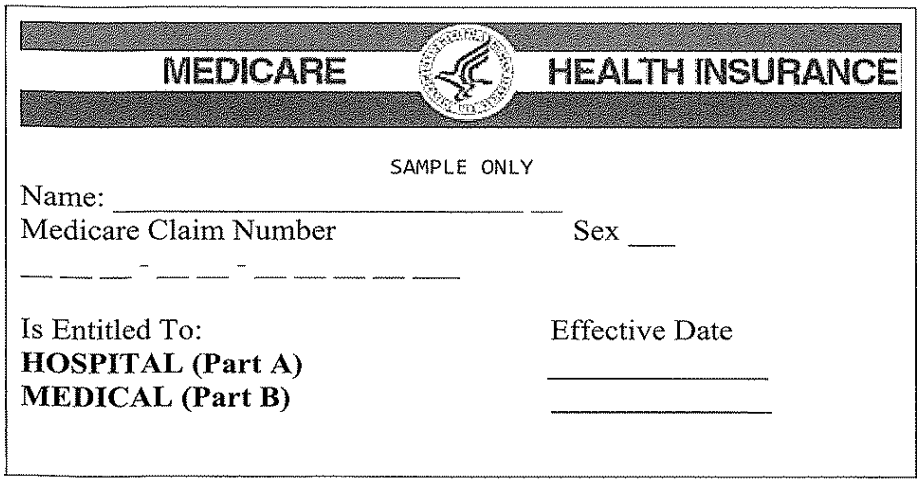
****Please be sure to include a voided check from the account listed above.**

A $20.00 service fee will be assessed in the event of non-sufficient funds.

TERMS AND CONDITIONS

1. You do not need more than one Medicare supplement, Medicare cost or Medicare select policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement, Medicare cost or Medicare Select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement, Medicare cost or Medicare select policy can be suspended, if requested, during your entitlement to benefits under Medicaid for up to 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, Medicare cost or Medicare select policy, or, if that is no longer available, a substantially equivalent policy, will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement, Medicare cost or Medicare select policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for and have enrolled in a Medicare supplement or Medicare cost 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 or Medicare cost 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 or Medicare cost policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement or Medicare cost policy or, if that is no longer available, a substantially equivalent policy will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement or Medicare cost policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state or provide advice concerning your purchase of Medicare supplement or Medicare cost 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). See the booklet "Wisconsin Guide to Health Insurance for People with Medicare" which you received at the time you were solicited to purchase this policy.

(Please complete card below if you do not have a copy of your Medicare card)



TERMS AND CONDITIONS

By signing this application below, I understand and agree that:

a) All statements and answers I've given are complete and true to the best of my knowledge and belief; and

b) The policy I hereby apply for will be effective only when MercyCare HMO, Inc. approves this application. Evidence of such approval will be issuance of policy. The effective date will be the date shown on the I.D. card issued.

I understand that information in this application will be used by MercyCare HMO, Inc. to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the MercyCare HMO, Inc. Medicare Supplement Policy if issued by MercyCare HMO, Inc. to me. I agree that MercyCare HMO, Inc. may release said information to its representative(s) or other person(s) performing business or legal services in connection with my claim(s) or as may be otherwise permitted by law or as I may further authorize from time to time.

I understand that I may request and receive a copy of this authorization. I understand that this authorization is revocable upon advance written notice given to MercyCare HMO, Inc. at its own office in Janesville, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and MercyCare HMO, Inc., its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand that this authorization will remain valid for two years from the date I, or my legal representative, execute this authorization. I further understand that a photographic copy of this authorization is as valid as the original.

I understand that no insurance agent or broker can modify, waive or change in any way this application; any requirement imposed by MercyCare HMO, Inc. nor bind any coverage or guarantee approval of this application. I further understand and agree that MercyCare HMO, Inc., its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorney's fees), I suffer as a result of any improper advice, action or omission on the part of any health care provider.

I HEREBY AUTHORIZE the Centers for Medicare & Medicaid Services to furnish information to MercyCare HMO, Inc. affirming my entitlement to Hospital Insurance Benefits (Part A) and enrollment for Replacement Medical Insurance Benefits (Part B) under title XVIII of the Social Security Act and to furnish the plan information as to Part A and Part B benefits recorded, including those based on services not furnished by or through the plan, and should any enrollment be terminated, the effective month of such termination for its use in connection with operation of this plan, I also authorize MercyCare HMO, Inc. or any other holder of medical or other information to release to the Centers for Medicare & Medicaid Services or its intermediaries or carriers any information needed to administer title XVIII of the Social Security Act.

I RECEIVED THE MERCYCARE SENIOR OUTLINE OF COVERAGE BEFORE COMPLETING THIS APPLICATION, AND AFTER CONSIDERING ALL FACTORS I BELIEVE THAT THE MERCYCARE HMO, INC. SENIOR POLICY SUITS MY NEEDS.

Date _____

Applicant's Signature _____

Read and sign the following notice only if you intend to replace your current Medicare supplement policy with MercyCare Senior

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

MercyCare Senior

MercyCare Health Plans • PO Box 550 • Janesville, WI 53547-0550

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

According to your application or other information you have furnished, you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a policy to be issued by MercyCare HMO, Inc. (referred to as "MercyCare" in this notice). Your new policy will provide thirty (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 the purchase of this Medicare supplement, Medicare cost, Medicare select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select 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 MERCYCARE, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement, Medicare cost, Medicare select or Medicare Advantage policy will not duplicate your existing Medicare supplement, Medicare cost, Medicare select or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare cost, Medicare select coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

☐ Additional benefits ☐ Fewer benefits and lower premium

☐ No change in benefits, but lower premium ☐ Not Applicable

☐ My plan has prescription drug coverage and I am enrolling in Medicare Part D.

☐ Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment:

_____

☐ Other (please specify) _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing 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.
2. State law provides that your replacement policy or certificate may not contain new preexisting condition waiting periods. The insurer will waive any time periods applicable to preexisting conditions waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.

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

_____ _____

Signature of MercyCare Representative Date

Applicant Name: _____ Address: _____

_____ _____

Applicant's signature Date

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Live well.
We'll insure you do.™

MercyCare Health Plans™

MercyCare Health Plans
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MercyCareHealthPlans.com

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