Priority Health

Medigap

Medicare supplement plan application

Section 1: Personal information

Last name	First name	Middle initial	Social Security number - -

Primary street address	City	State	ZIP code

Mailing street address (if different from above)	City	State	ZIP code

County	Phone number that we may use to contact you ☐ Landline (home phone) ☐ Cell phone	Alternate number that we may use to contact you (optional) ☐ Landline (home phone) ☐ Cell phone

Email address	Gender ☐ Male ☐ Female	Birth date (MM/DD/YYYY) / /

Medicare number (as shown on your Medicare red, white and blue card)	Medicare Part A effective date / /	Medicare Part B effective date / /

Please indicate your requested effective date (must be first of month, i.e. MM/01/YYYY):
/ 01 /

Note: If your birthday is on the first of the month, your Medicare-effective date is the first of the previous month.

Your coverage will become effective on the first day of the month following receipt of your completed application, or a date specified above (date must be in the future). You will receive an ID card and a certificate of coverage with a letter confirming your effective date and premium.

Household discount

You may be eligible for a 12% reduction in your monthly premium if another person in your household* currently has or is enrolling in a Priority Health Medigap plan.

Does someone in your household currently have or are they enrolling in a Priority Health Medigap plan?

☐ **Yes**. ☐ **No**. **Skip to section 2.**

If yes, please check the box below that applies to you:

☐ I reside with a person who's currently covered under a Priority Health Medigap plan.
Name of person_____
Priority Health contract number of person _____
(Contract number is the 11-digit number found on the Priority Health member ID card)

Section 1: Personal information (continued)

☐ I reside with a person who is in the process of applying for a Priority Health Medigap plan.
Name of person as it appears on their red, white and blue
Medicare insurance card _____
Medicare number of person _____

**A household is defined as a condominium unit, a single-family home or an apartment unit within an apartment complex. Assisted living facilities, group homes, adult day care facilities, nursing homes or any other health residential facilities are not included in the definition of a household. You do not need to be related to the other qualifying members of your household to receive this discount. The discounted rate will apply as long as each policy considered for the discount remains in effect.*

Section 2: Select a Priority Health Medigap plan

Please read the following statements carefully before applying.

- You must be enrolled in Medicare Parts A and B.
- You cannot have more than one Medigap plan and Medigap plans cannot work with Medicare Advantage plans. If you are enrolled in an existing Medigap plan, or, if applicable, a Medicare Advantage plan, you must intend to terminate your existing Medigap plan or leave your Medicare Advantage plan. Enrolling in a new Medigap policy will not automatically disenroll you from any current Medicare Advantage or Medigap plan. This may potentially cause you to owe monthly premiums on both active plans.
- Refer to the Outline of Coverage for the monthly premium and description of the plan.
- You must be a permanent resident of Michigan at the time of enrollment.
- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- Your coverage will automatically renew each year as long as you pay your premium and you continue to meet all other eligibility requirements.
- Counseling services may be available in your state to provide advice concerning your purchase of Medigap insurance and concerning medical assistance through the state Medicaid program.

Please select which plan you are applying for:

☐ Plan A ☐ Plan D ☐ Plan G ☐ Plan N

Only beneficiaries first eligible for Medicare due to age or disability before January 2020 may apply for plans C and F.

☐ Plan C ☐ Plan F

For applicants under age 65: *If you are under the age of 65 and have Medicare due to a disability, you are not eligible to enroll in Plans F, G, or N.*

Section 3: Benefits under Medicaid

If you are eligible for benefits under Medicaid, you may not need a Medigap plan.

1. Are you covered for medical assistance through the state Medicaid program?
   (Note: If you are participating in a Spend-Down Program and have not met your share of cost, please answer NO to this question.)
   - ☐ **Yes. Continue to Question 2.**
   - ☐ **No. Skip to Section 4.**

2. Will Medicaid pay your premiums for this Medigap plan?
   - ☐ **Yes.**
   - ☐ **No. Continue to Question 3.**

3. Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium?
   - ☐ **Yes. You are not eligible for this Medigap plan.**
   - ☐ **No. Continue to Section 4.**

If after purchasing this plan you become eligible for Medicaid, the benefits and premiums under your Medigap plan can 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 Medigap 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.

Section 4: Determing Medigap eligibilty

The Medigap open enrollment period is a one-time only, six-month period when federal law allows you to buy any Medigap policy that's sold in your state. It starts in the first month that you're both covered under Medicare Part B and 65 or older. During this period, you can't be denied a Medigap policy or charged more due to past or present health problems. This applies to Medigap plans C and F, if you were eligible for Medicare prior to January 1, 2020, as well as, plans A, D, G, and N. **If you are under 65 years of age and will not turn 65 by your requested effective date, you need to respond to all the questions in this section.**

1. Are you enrolled in Medicare Part B?
   - ☐ **Yes. Continue to Question 2.**
   - ☐ **No. You are not eligible to enroll in a Medigap plan. You must be enrolled in Medicare Part B to enroll in a Medigap plan.**

2. Are you age 65 or older and did you first enroll in Medicare Part B in the last six months?
   - ☐ **Yes. You will be accepted into a Priority Health Medigap plan with a preferred premium, skip to Section 7.**
   - ☐ **No. Continue to Question 3.**

Section 4: Determing Medigap eligibilty (continued)

3. Are you both:
   - Enrolled in Medicare Part B and
   - 65 within the last six months or will turn 65 by (or during) the month of your requested effective date?*

   ☐ **Yes. You will be accepted into a Priority Health Medigap plan with a preferred premium, skip to Section 7.**
   ☐ **No. Continue to Question 4.**

   **If your birthday is on the first of the month, your Medicare-effective date is the first of the previous month. Please answer yes to this question.*

4. Are you under the age of 65 and enrolled in Medicare Part B due to a disability?
   ☐ **Yes. Continue to Question 5.**
   ☐ **No. Skip to Section 5.**

5. Are you currently enrolled in a Medigap plan, Medicare Advantage plan or other health insurance?
   ☐ **Yes. Complete the below required information, then skip to Section 6.**
   Start date: _____/____/____ End date: _____/____/____ *(Leave end date blank if still enrolled.)*
   Current insurer:

   _____

   Reason for leaving (please explain):

   _____

   _____

   ☐ **No. Continue to Question 6.**

6. Have you lost, or will you lose, coverage under a group policy after becoming eligible for Medicare?

   ☐ **Yes. If yes, indicate the date you lost or will lose coverage: _____/_____/_____**
   Skip to Section 6.

   If you're younger than 65 and applying for Plan A or D because you've lost coverage under an individual or group policy after becoming eligible for Medicare, you must submit proof that you've lost coverage due to these circumstances. **Please include a copy of the termination notice with this application.**

   ☐ **No. Skip to Section 6.**

Section 5: Determining if you qualify for guaranteed issue or Trial Right

Guaranteed issue rights are the rights you have in certain situations when insurance companies are required by law to sell or offer you a Medigap policy. In these situations, an insurance company can't deny you a Medigap policy, or place conditions on a Medigap policy, such as exclusions for pre-existing conditions, nor can you be charged more for a Medigap policy because of a past or present health problem. **If you are under 65 years of age and will not turn 65 by your requested effective date, you need to respond to all the questions in this section.**

1. Are you enrolled, or were you previously enrolled, in a Medicare Advantage plan?
   - ☐ **Yes; indicate start date:** ____/____/____ **end date:** ____/____/____
     (Note: Leave end date blank if you are still enrolled.)
     Previous insurer: _____
   - ☐ **No. Continue to Question 2.**

2. Are you enrolled, or were you previously enrolled, in a Medigap policy?
   - ☐ **Yes; indicate start date:** ____/____/____ **end date:** ____/____/____
     (Note: Leave end date blank if you are still enrolled.)
     Previous insurer: _____
   - ☐ **No. Continue to Question 3.**

3. Have you received a termination notice from one of the following that you are losing health coverage through no fault of your own?
   - Employer group health plan
   - Health care insurance provider
   - Employer
   - Health plan such as COBRA or union coverage

   - ☐ **Yes; indicate start date:** ____/____/____ **end date:** ____/____/____
     Previous insurer: _____
     Please include a copy of the termination notice with this application. You will be accepted into a Priority Health Medigap plan with a preferred premium, **skip to Section 7**.
   - ☐ **No. Continue to Question 4.**

4. Are you losing coverage because you are moving out of your Medicare Advantage (or Medicare SELECT) plan's service area and your current plan is not available in your new location?
   - ☐ **Yes. You will be accepted into a Priority Health Medigap plan with a preferred premium,**
     skip to Section 7.
   - ☐ **No. Continue to Question 5.**

Section 5: Determining if you qualify for guaranteed issue or Trial Right (continued)

5. Did you join a Medicare Advantage Plan (or PACE) when you were first eligible for Medicare Part A at age 65, and within the first year of joining said plan, you have decided to switch to Original Medicare and join a Medigap plan? This is considered a "Trial Right."

   ☐ **Yes. You will be accepted into a Priority Health Medigap plan with a preferred premium, skip to Section 7.**

   ☐ **No. Continue to Question 6.**

6. Did you previously terminate a Medigap policy to join a Medicare Advantage plan (or switch to a Medicare SELECT policy) for the first time within the last 12 months, and now wish to return to a Medigap policy?

   This is considered a "Trial Right." To exercise your Trial Right, you must return to your previous Medigap policy unless it is no longer available. **You will be required to provide proof that your plan is no longer available.**

   ☐ **Yes.**

   - If your previous Medigap plan is still available, you must return to that plan. To apply for a Medigap plan with Priority Health you will have to answer medical questions to determine acceptance and premium, **continue to Section 6**.
   - If your previous Medigap plan is NOT available, you will be accepted into a Priority Health Medigap plan with a preferred premium, **skip to Section 7**.

   ☐ **No. Continue to Question 7.**

7. Are you voluntarily dis-enrolling from your current plan and selecting a Priority Health Medigap plan for one of the following reasons?

   ☐ **Yes. (You must check a reason below, then continue to Section 6.)**

   ☐ I want additional benefits

   ☐ I want a lower premium

   ☐ I want to move from my current Medicare Advantage plan to a Priority Health Medigap plan during an eligible enrollment period

   ☐ I want to move from my current Medigap plan to a Priority Health Medigap plan

   ☐ Other (please explain) _____

   _____

   ☐ **No. Continue to Section 6.**

Section 6: Health information

(Applicants under 65 and enrolled in Medicare due to a disability must answer all health information questions. Applicants over 65 and in their guaranteed issue or open enrollment period may skip to section 7) **If you are under 65 years of age and will not turn 65 by your requested effective date, you need to respond to all the questions in this section.**

A. If you enrolled in Medicare before your 65th birthday due to a disability, please explain the nature of your disability.

1. Do any of these apply to you? ☐ **Yes (Please check all that apply).** ☐ **No.**

- ☐ End stage renal (kidney) disease
- ☐ Currently receiving dialysis
- ☐ Diagnosed with kidney disease that may require dialysis
- ☐ Admitted to hospital as in-patient within the past 90 days

2. Within the past two years, has a medical professional recommended or discussed as a treatment option any of the following that has NOT been completed:

☐ **Yes (Please check all that apply).** ☐ **No.**

- ☐ Hospital admittance as an inpatient
- ☐ Organ transplant
- ☐ Back or spine surgery
- ☐ Joint replacement
- ☐ Heart surgery
- ☐ Surgery, radiation or chemotherapy for cancer
- ☐ Vascular surgery

If you checked any choices in section 6A and you are age 65+, unfortunately you are not eligible for this Medigap plan.

If you checked any choices in section 6A and you are under age 65 and on disability, continue to Section 6B. If you did not check any choices in section 6A, are not on disability, and enrolled in Medicare Part B less than three years ago, you will be accepted into a Priority Health Medigap plan with a preferred premium, skip to Section 7.

B. 1. Have you had, or been diagnosed with or treated for, any of the following in the past two years?

☐ **Yes (Please check all that apply).** ☐ **No.**

- ☐ Cancer or leukemia (except basal cell skin cancer)
- ☐ Alzheimer's disease or dementia
- ☐ Angina pectoris, heart attack, coronary artery disease, congestive heart failure, stroke, peripheral vascular disease, abnormal heart rhythm (including pacemaker implantation) and/or carotid artery disease
- ☐ Chronic kidney or liver disease
- ☐ Systemic lupus erythematosus, rheumatoid arthritis
- ☐ Complications of diabetes, including kidney disorder, neuropathy and/or retinopathy
- ☐ Organ or bone marrow transplant
- ☐ Parkinson's disease, amyotrophic lateral sclerosis (ALS), multiple sclerosis, paraplegia, quadriplegia or hemiplegia

If you checked any choices in Section 6B and you are age 65+, you are not eligible for this Medigap plan.

If you did not check any choices in Section 6B, or you did, but are under 65 and on disability, continue to Section 6C.

Section 6: Health information (continued)

C. 1. **Height:** _____ ft. _____ in. **Weight:** _____ lbs.

2. **Have you used nicotine in any form in the past year?** ☐ **Yes.** ☐ **No.**

3. Are you taking prescription medication(s) for any health condition(s)? ☐ **Yes.** ☐ **No.**
   If yes, what condition(s) are you taking medication(s) for?

   _____

   _____

4. Have you suffered any falls or other accidental injuries in the past three years? ☐ **Yes.** ☐ **No.**
   If yes, please provide details:

   _____

5. Do you have any of the following chronic health conditions?
   ☐ **Yes (Please check all that apply).** ☐ **No.**
   ☐ arthritis ☐ osteoporosis ☐ asthma ☐ hypertension ☐ hyperlipidemia
   ☐ clotting disorder ☐ diabetes ☐ depression
   ☐ other—please specify: _____
   ☐ Melanoma or Metastatic skin cancers ☐ Liver fibrosis or cirrhosis
   ☐ COPD, emphysema, or any lung disorder requiring oxygen

6. Please list the date of your last doctor's visit: ____/____/____
   Please list symptoms you were having, test results, diagnosis and/or treatment(s):

   _____

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

Continue to Section 7.

Section 7: Payment information

☐ Electronic funds transfer (EFT) from your bank account on the first of each month.
☐ Receive a bill monthly and pay the plan directly by mail or by phone.

For EFT, Priority Health will debit the checking or savings account you designate in the amount of your outstanding premium on the first business day of every month. You can request a monthly informational only statement by calling Priority Health customer service. If you have questions about the automatic bill payment plan, please contact customer service at 800.852.9780 (TTY users call 711). Your first draft may be for two months' payments. If your bank account does not have sufficient funds to cover your plan's premium payment, Priority Health reserves the right to charge a non-sufficient funds (NSF) fee up to the amount allowed by the state of Michigan, which is $25.

Name of financial institution	Account type ☐ checking ☐ 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 (Please sign in blue or black ink)	Date ____/____/____

This form can only be accepted with a handwritten signature on a physical piece of paper. Electronic, digital, or typed signatures cannot be accepted.

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.

If you are enrolled in a Medigap policy by reason of disability and later become covered by an employer or union-based group health plan, you can suspend your Medigap policy. You must make that request to Priority Health while you are covered under the employer or union-based group health plan. If you lose the employer or union-based group health plan, you can reinstate your Medigap plan, if available, by requesting that within 90 days of losing the employer or union-based group health plan. If the Medigap plan is no longer available, you will have a substantially equivalent plan reinstated. If the Medigap 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 the suspension.

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 Plan 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/or 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 make 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 if Priority Health has not received my plan premium by the first of the month, they will send a notice letting me know that my membership in the Priority Health Medigap plan may end if they do not receive my premium payment in full, within 60 calendar days.

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 **but if I do not provide it, I may not be eligible for enrollment.** 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.

Note: If you would like a copy of this application for your records, please print or make a copy before submitting.

Applicant printed name	
Applicant signature (Please sign in blue or black ink)	Date / /

This form can only be accepted with a handwritten signature on a physical piece of paper. Electronic, digital, or typed signatures cannot be accepted.

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

Personal representative's printed name			
Personal representative's signature (Please sign in blue or black ink)		Date / /	
This form can only be accepted with a handwritten signature on a physical piece of paper. Electronic, digital, or typed signatures cannot be accepted.			
Street address	City	State	ZIP code
Phone	Relationship to applicant *(i.e.: Power of Attorney or legal guardian):*		

To help keep our records up-to-date and/or if additional actions need to take place on behalf of the member once enrolled, you may provide documentation to help verify guardianship agreements by either scan and email or mail legal documents to:
Priority Health, MS 1115, 1231 E. Beltline Ave, NE, Grand Rapids, MI 49525
or email *MedicareCS@priorityhealth.com*.
You may also create a member account and send the documentation via secure message.

Section 9: Agency form

(To be completed by insurance agent)

1. Have you sold any other health plan policies to this individual that are still in force?
   - ☐ **Yes. Policy description(s):**

     _____

     _____
   - ☐ **No.**

2. Have you sold any health plan policies to this individual in the last five (5) years that are not still in force?
   - ☐ **Yes. Policy description(s):**

     _____

     _____
   - ☐ **No.**

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

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

Street address	City	State	ZIP code
Email address*	Primary phone	Fax	
Writing agent printed name		Agent number	
Writing agent signature		Date / /	

**Email address required if you want us to copy you on anything we send to the applicant.*

Notice to applicant regarding replacement of Medigap 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 Medigap 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. The replacement of coverage involved in this transaction does not duplicate your existing Medigap coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medigap 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) _____
- ☐ *Did not* replace existing Medigap coverage

If you are currently in a Medicare Advantage or Medigap plan, and if you receive your acceptance letter for this Priority Health Medigap plan, please make sure to disenroll from your current Medicare Advantage or Medigap plan. If you are enrolled in a Priority Health plan, you can terminate your plan by notifying us in writing or by calling customer service 30 days prior to termination. 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 (Please sign in blue or black ink)		Date / /	
This form can only be accepted with a handwritten signature on a physical piece of paper. Electronic, digital, or typed signatures cannot be accepted.			
Printed name of applicant			
Applicant's street address	City	State	ZIP code
Policy, certification or contract number being replaced			

Applications can be submitted online at *prioritymedicare.com*, emailed, faxed or mailed.

Email – scan and email to *PH-Medigap@priorityhealth.com*

Fax – 616.942.7204

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

Priority Health
Medicare Enrollment, MS 1175
1231 East Beltline Ave NE
Grand Rapids, MI 49525