

Application for Medicare Supplement Insurance

National Health Insurance Company
 PO Box 95464, Cleveland, OH 44101

Toll-free telephone: (888) 966-2345 • www.natgenhealth.com • Fax: (888) 344-3232

New Business Conversion Reinstatement

Section A. Applicant Information				
First Name	Middle Name	Last Name		
Social Security Number	Medicare Claim Number	<input type="checkbox"/> Male <input type="checkbox"/> Female		
Date of Birth ____/____/____ (mm/dd/yyyy)	Current Age	State and Country of Birth		
Residence Address	City	State	Zip Code	
Mailing Address (if different)	City	State	Zip Code	
Home Telephone Number	Mobile Telephone Number	Email Address		
Section B. Plan and Billing Information				
Did you first become eligible for Medicare due to age, disability or end-stage renal disease prior to January 1, 2020? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Plan Applied For: <input type="checkbox"/> Plan A <input type="checkbox"/> Plan B <input type="checkbox"/> Plan F* <input type="checkbox"/> Plan G <input type="checkbox"/> Plan N *Plan F and Plan High F only available to applicants eligible for Medicare prior to 2020.		Select Policy Premium Payment Option (check only one) Bank Draft (EFT): <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly <input type="checkbox"/> I Authorize Bank Draft Payments Direct Bill: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly		
Have you lived with any of the following people for the past 12 months and still live with them currently? Check all that apply: <ul style="list-style-type: none"> <input type="checkbox"/> Legal Spouse <input type="checkbox"/> Domestic or Civil Union Partnership <input type="checkbox"/> 1 to 3 Other Adults Age 50 or Older 				
If so, list the name of the household resident(s): _____				
Application Fee: \$25 Initial Premium: \$ _____ Total Amount Submitted: \$ _____	Requested Policy Effective Date ____/____/____ (mm/dd/yyyy)	[Draft Initial Premium on ____/____/____ (mm/dd/yyyy)]		
Bank Routing # (9 digits)		Bank Account # (do not include check #)		
: _____:		_____		
Bank Name: _____		Name(s) of Depositor(s): _____		
Account Type: <input type="checkbox"/> Checking <input type="checkbox"/> Savings		Select Bank Draft Day _____ (1 st – 31 st)		
If paying premium by Bank Draft, please include a voided check. The first draft will occur on the date your application is approved by NHIC (unless specified otherwise). All Checks will be processed as EFT (Electronic Funds Transfer) from your bank.				
Section C. Medicare and Insurance 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 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.**

Answer all questions to the best of your knowledge. Mark "YES" or "NO" with an "X" to the questions below.

1. Did you enroll in Medicare Part B within the past six months? Yes No

2. Did you turn age 65 within the past six months? Yes No

Medicare Part A Effective Date

____/____/____(mm/dd/yyyy)

Medicare Part B Effective Date

____/____/____(mm/dd/yyyy)

3. Are you applying during a guaranteed issue period? (NOTE: If "Yes," please **attach proof of eligibility.**) Yes No

4. Do you have another Medicare Supplement or Medicare Select insurance policy in force? Yes No

If yes:

(a) Name of Company _____ Plan ____ Effective Date ____/____/____(mm/dd/yyyy)

(b) Do you intend to replace your current Medicare Supplement policy with this policy? Yes No
(If yes, complete the Replacement Notice)

(c) Indicate termination date ____/____/____(mm/dd/yyyy)

5. 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" blank.

Start ____/____/____(mm/dd/yyyy) End ____/____/____(mm/dd/yyyy)

(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, complete the Replacement Notice.) Yes No

(b) Describe reason for termination _____

(c) Planned date of termination ____/____/____(mm/dd/yyyy)

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

(e) Did you drop a Medicare Supplement or Medicare Select policy to enroll in this plan? Yes No

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

If yes:

(a) Name of company and type of policy _____

(b) Start date ____/____/____(mm/dd/yyyy) End date ____/____/____(mm/dd/yyyy)

(c) Reason for termination _____

7. 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 yet met your "Share of Cost," please answer "No" to this question.)

(a) If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No

(b) If yes, do you receive any benefits from Medicaid **other than** payment toward your Medicare Part B premium? Yes No

8. Have you received a copy of the **Guide to Health Insurance for People with Medicare**, the **Outline of Coverage**, and the **Notice of Information Practices**? Yes No

Section D. Health Information

For applicants applying as an Open Enrollee or under Guarantee Issue rights, skip sections D, E and F.

The information I provided on this enrollment form is complete, true and accurate to the best of my knowledge and belief. I realize that any incomplete, false, or inaccurate statement or material misrepresentation in the enrollment form may result in cancellation of my coverage, a change in my premium, or a rescission of my coverage.

Signature of Applicant: _____ **Date:** _____ (mm/dd/yyyy)

For underwriting purposes provide the name and address of your primary care physician

Name: _____

Address: _____

Please read through each question carefully and indicate any of the conditions that apply with a check mark in the box.

Applicant's Height _____ ft _____ in Weight _____ lbs	When last have you used tobacco in any form, or used nicotine products including a patch, gum, or electronic cigarettes? _____/_____ (mm/yyyy) <input type="checkbox"/> Never
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1. Currently or within the past 1 month have you had, been diagnosed with, been treated or advised to have treatment for, or tested positive for?

- Diabetes with complications such as numbness, kidney disease, heart disease, stroke, eye disease, or skin ulcers
- Arthritis or Spinal Stenosis which requires joint replacement surgery, or requires continuous use of opioid pain medications, or is crippling or disabling
- None of the above

2. Currently or within the past 1 month, have you?

- Had any recommended or required medical evaluations, treatments, or surgeries that have not yet been completed
- Received help with movement, toileting, eating or dressing Received speech therapy
- Received services from an Assisted Living Facility Received oxygen therapy
- Been hospitalized or were confined to a bed Had Kidney Dialysis
- Required use of a Cardiac Pacemaker or Defibrillator
- None of the above

3. Within the past 2 years have you had, been diagnosed with, been treated or advised to have treatment for, or tested positive for?

Circulatory disease (do not check any circulatory conditions below if taking only high blood pressure or high cholesterol type medications for prevention or maintenance).

- Peripheral Vascular / Arterial Disease Blood disorder (excluding mild anemia) Stroke
- Cardiac Chest Pain (Angina) Chronic Atrial Fibrillation Heart Attack
- Transient Ischemic Attack Deep Venous Thrombosis Embolus
- None of the above

Cancer

- Leukemia, Myeloma or Lymphoma Internal Cancer Melanoma
- None of the above

Neurological disorders

- Muscular Dystrophy Multiple Sclerosis Transverse Myelitis
- Huntington's disease
- None of the above

Autoimmune disorders

- Systemic Scleroderma Systemic Lupus
- None of the above

3. Within the past 2 years have you had, been diagnosed with, been treated or advised to have treatment for, or tested positive for?

Other disorders or conditions

- Osteoporosis with bone fractures
- Osteoporosis by injections or infusions
- Pituitary disease or disorder
- None of the above
- Drug or Alcohol abuse
- Amputation due to disease
- Enzyme disorders
- Adrenal gland disorders

4. Within the past 2 years have you been hospitalized or required treatment in an Emergency Room for any of the following?

- Blood Pressure Crisis
- Depression
- 2 or more times for the same condition
- None of the above
- Asthma
- Ulcerative Colitis
- Epilepsy (Seizures)
- Crohn's Disease

5. Within the past 10 years have you had, been diagnosed with, been treated or advised to have treatment for, or tested positive for:

- Chronic Obstructive Pulmonary Disease
- Renal Failure
- Cognitive disorder
- Schizophrenia
- Hepatitis B
- Organ Transplant
- Enlarged Heart
- None of the above
- Emphysema
- Alzheimer's Disease
- ALS (Amyotrophic Lateral Sclerosis)
- AIDS, ARC or HIV infection
- Cirrhosis
- Congestive Heart Failure
- End Stage Renal Disease
- Chronic Bronchitis
- Dementia
- Parkinson's Disease
- Bipolar Disorder
- Myasthenia Gravis
- Cardiomyopathy

6. Excluding oral medications- have you been advised that surgery, injections, infusions, brain or nerve stimulation, focused ultrasound, dialysis, oxygen therapy or any other type of treatment will be required for?

- Tremors
- Crohn's disease
- Weight Loss (Bariatric surgery only)
- Organ, Tissue, or Bone Marrow Transplant
- Hepatitis C (including treatment by oral medications)
- Pulmonary disease (OSA on CPAP without oxygen is acceptable)
- None of the above
- Cataracts
- Macular Degeneration
- Gallstones
- Ulcerative Colitis
- Aneurysm
- Heart Valve Disease
- Coronary Artery Disease
- Kidney Disease
- Osteoporosis

List prescriptions you've taken in the last 12 months and reason for taking them.

Medication	Reason taken	Dose	Frequency	Still taking?
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

Comments on medical conditions or medications-

Section F. Disclosure, Acknowledgements, and Agreement

Disclosure:

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can 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.
5. 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.
6. 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).

Acknowledgments and Agreement:

I wish to apply for Medicare Supplement insurance coverage. I acknowledge that I have received or been given access to review: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

I HAVE READ AND FULLY UNDERSTAND the questions and my answers on this application. To the best of my knowledge and belief they are true and complete. I understand the Company may conduct a telephone interview with me regarding the answers. I understand and agree the policy applied for will not take effect until issued by the Company, and that the agent is not authorized to extend, waive or change any terms, conditions or provisions of the coverage.

Caution: If your answers on this application are incorrect or untrue, the Company has the right to deny benefits or rescind your coverage.

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, which is a crime and subjects such person to criminal and civil penalties.

Applicant's Signature: _____

Signed at (City and State): _____ Date: _____ (mm/dd/yyyy)

Section G. Agent Statement

Type of Sale: Telephone In Person Internet Mail Other _____

Yes No

Did anyone assist the proposed insured in completing the application or answering the application questions?
Name _____ Relationship to the Applicant _____
Type of assistance provided _____

1. Did you review the Application for correctness and any omissions?

2. Did the Applicant review the Application for correctness and any omissions?

3. Are you related to the Applicant?

If Yes, provide relationship: _____

Listed below are all other health insurance policies I have (a) sold to the Applicant which are still In force; and (b) sold to the Applicant in the last 5 years which are no longer in force.

Company	Type of Policy	Effective Date	In Force
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given the Applicant an **Outline of Coverage** for the policy being applied for, the **Guide to Health Insurance for People on Medicare**, and the **Notice of Information Practices**; and 3) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

Agent Signature: _____ Date: _____ (mm/dd/yyyy)

Health Information Authorization

This Authorization complies with the HIPAA Privacy Rule

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, or other health care provider that has provided services, treatment or payment to me, or on my behalf, within the past 10 years ("My Providers"), or consumer reporting agency, to disclose my entire medical record and any other protected health information concerning me to National Health Insurance Company ("NHIC") and its agents, employees and representatives. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes and excludes information related to genetic tests or genetic services (except to pay a claim related to such tests or services).

In addition I authorize MIB, Inc., and any MIB member insurer, to provide any medical or personal information that it has about me to NHIC, its reinsurer or any MIB-authorized third-party administrator performing underwriting services on NHIC's behalf. I also authorize NHIC, its reinsurer or authorized third-party administrator, to make a brief report of my personal health information to MIB, Inc.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose my entire medical record without restriction.

My protected health information is to be disclosed under this Authorization so that NHIC may: **1)** underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; **2)** obtain reinsurance; **3)** administer claims and determine or fulfill their responsibility for coverage and provision of benefits; **4)** administer coverage; and **5)** conduct other legally permissible activities that relate to any coverage I have or have applied for with NHIC.

For a period of 120 days from the date of this Authorization I authorize my NHIC Producer to receive certain protected health information about me that is related to an adverse underwriting decision or counteroffer for alternative coverage made during the underwriting of my application.

This Authorization shall remain in force for 30 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to: **NHIC at PO Box 1070, Winston-Salem, NC 27102-1070, Attention: Privacy Officer.** I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that NHIC has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, NHIC may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments.

Name of Applicant (please print)

Signature of Applicant or Personal Representative

Date of Birth

Date

Description of Personal Representative's Authority or Relationship to Applicant (if applicable)

(Return to Company)

N-HHA-MS-M