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	☐ Male ☐ 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

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) ☐ Never

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? ☐ Yes ☐ No

Plan Applied For:
☐ Plan A ☐ Plan F* ☐ Plan High F*
☐ Plan G ☐ 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): ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly

☐ **I Authorize Bank Draft Payments**

Direct Bill: ☐ Annual ☐ Semi-Annual ☐ 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:

☐ Legal Spouse
☐ Domestic or Civil Union Partnership
☐ 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: ☐ Checking ☐ Savings Select Bank Draft Day _____________ (1st – 31st)

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? (If yes, complete the Replacement Notice) ☐ Yes ☐ No

(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? (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.) ☐ Yes ☐ No

(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 recission 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.

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

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

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

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

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

Medication	Reason taken	Dose	Frequency	Still taking?
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ 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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ 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)