



Asuris Medigap (Medicare Supplement) Application

SPECIAL NOTICE

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- 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 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.
- 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 not 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 specified low-income Medicare beneficiary (SLMB).

INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

Thank you for selecting Asuris Northwest Health for your Medicare Supplement Coverage. You must have both Medicare Part A and Part B to apply for these plans.

To assure prompt processing of your application, please be sure to:

1. Answer each required question completely **using ink**.
2. Copy the information from your Medicare Identification Card into Section 2 of this application.
3. Sign and date the statements in Section 8 of this application. If you choose our automatic bank withdrawal, complete Section 6.
4. If you need assistance completing this application, please contact our Sales Department at 1-866-704-2708 or contact your independent producer.

Yes No I want to do my part for the environment and reduce waste. Please send my Explanation of Benefits (and when possible, other communications) electronically.

My e-mail address is: _____

SECTION 1 - PLAN SELECTION

Choose ONE of the four standard plans:

- Pledge Plan A Pledge Plan C
 Pledge Plan F Pledge Plan K

SECTION 2 - ENROLLMENT INFORMATION

Applicant Last Name		First Name, MI		Gender	Age
Height	Weight	Birthdate	Social Security Number		
Medicare Insurance Number			Medicare Effective Dates (from your Medicare card): PART A (Hospital) _____ PART B (Physician) _____		

WASHINGTON RESIDENCE ADDRESS

To be eligible to apply for our Medicare Supplement plans, you must reside in our service area. A photocopy of a valid Washington state driver's license, identification card, or current utility bill with name and address may be requested as proof of residency.

Residence Street Address		
City, State, ZIP Code		
Mailing Address (if different than residence street address)		
E-Mail Address (will not be disclosed outside of the company)		
Home Phone Number	Work Phone Number	County

SECTION 3 - OTHER COVERAGE 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.

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE
(Please mark Yes or No with an "X")

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| A. Did you turn 65 in the last 6 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Did you enroll in Medicare Part B in the last 6 months?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If Yes, what is the effective date _____

- | | | |
|---|--------------------------|--------------------------|
| C. Are you covered for medical assistance through the state Medicaid program? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|
- (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, will Medicaid pay your rates for this Medicare supplement contract?.....

If Yes, do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium?.....

- | | | |
|---|--------------------------|--------------------------|
| D. Have 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)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave "End" blank. | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If Yes: Start _____ **End** _____

- | | | |
|--|--------------------------|--------------------------|
| E. Have you recently lost coverage for medical assistance through the state Medicaid program?..... | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If Yes, what date did coverage end _____

- | | | |
|--|--------------------------|--------------------------|
| F. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?..... | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

- | | | |
|---|--------------------------|--------------------------|
| G. Was this your first time in this type of Medicare plan?..... | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

- | | | |
|---|--------------------------|--------------------------|
| H. Did you drop a Medicare supplement policy to enroll in the Medicare plan?..... | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

- | | | |
|---|--------------------------|--------------------------|
| I. Do you have another Medicare supplement policy in force? | <input type="checkbox"/> | <input type="checkbox"/> |
|---|--------------------------|--------------------------|

If Yes, with which company and what plan do you have _____

If Yes, do you intend to replace your current Medicare supplement policy with this contract?.....

(Please complete the enclosed "Notice of Applicant Regarding Replacement of Medicare Supplement Coverage" form.)

- | | | |
|--|--------------------------|--------------------------|
| J. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
|--|--------------------------|--------------------------|

If Yes, with which company _____

If Yes, what kind of policy _____

If Yes, what are your dates of coverage under the other policy. If you are still covered under this plan, leave **"End"** blank.

Start _____ **End** _____

Authorization signature required on page 9.

SECTION 4 - MEDICARE SUPPLEMENT PROTECTION PERIODS

	Do I need to complete a Health Statement?			
	Applying for plan:			
	A	C	F	K
1. Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, stops giving care in your area, or you move out of the plan's service area, and you apply for Medicare supplement coverage after you receive notice that your coverage is terminating or ceasing, and no later than 63 days after your coverage terminates or ceases.	No	No	No	No
2. Your employer group coverage that supplements the benefits under Medicare ends or ceases to provide all such supplemental benefits to you, and you apply for Medicare supplement coverage after (a) your coverage terminates or ceases, or (b) you receive notice that your coverage is terminating or ceasing, whichever is later, and no later than 63 days after your coverage terminates.	No	No	No	No
3. Your Medicare supplement insurance company goes bankrupt and you lose your coverage, or your Medicare supplement policy coverage ends through no fault of your own, and you apply for Medicare supplement coverage beginning on the earlier of your coverage terminating or you receiving notice of termination or bankruptcy, and no later than 63 days after your coverage terminates.	No	No	No	No
4. You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medicare supplement policy that covers outpatient prescription medications, and you apply for Medicare supplement coverage up to 60 days before the initial Medicare Part D enrollment period and no later than 63 days after the effective date of your Medicare Part D coverage. Please enclose proof of enrollment in Medicare Part D.	No	No	No	No
5. You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare, and you apply for a Medicare supplement policy up to 60 days before and no later than 63 days after your Medicare Advantage or PACE program coverage terminates.	No	No	No	No
6. You dropped a Medicare supplement policy to join a Medicare Advantage plan, Medicare Select plan, or PACE program for the first time and now you want to leave. You have been in the plan for no more than a year, and you apply for a Medicare supplement policy up to 60 days before and no later than 63 days after your plan terminates. A Health Statement is not required if you enroll in the same Medicare supplement policy (with the same company) that you had previously, if available.	No	No	No	No
7. You leave a Medicare Advantage plan or drop a Medicare supplement (Medigap) plan because the company or its representatives haven't followed the rules, or mislead you, and you apply for a Medicare supplement policy up to 60 days before and no later than 63 days after your plan terminates.	No	No	No	No

SECTION 5 - HEALTH STATEMENT

- Yes No
- ♦ Are you applying for coverage to start within the six-month period immediately following your enrollment in Medicare Part B or your 65th birthday? (This is your **open enrollment period**.).....
 - ♦ If you answered "Yes" to the above question, continue to Section 6. You do not need to answer any more questions in Section 5.
 - ♦ If you answered "No" to above question, finish completing Section 5. Answer all of the questions in this section. **An incomplete application will be returned to you.**

Please Note: Congress has established a six-month open enrollment period for buying Medicare supplement health insurance (Medigap). The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

Other than the circumstances listed above, there are some exceptions where, completing the following health history questionnaire may not be required. If you would like to verify if one of these exceptions applies to you please see page 4 section 4 otherwise, please complete the following questionnaire:

A. Within the last five years, have you had diagnosis, treatment, or advice relating to any of the following:

	Yes	No		Yes	No
1. Accident, injury, or deformity.....	<input type="checkbox"/>	<input type="checkbox"/>	23. Lung problems, chronic obstructive pulmonary disease, emphysema or oxygen use	<input type="checkbox"/>	<input type="checkbox"/>
2. Acquired Immune Deficiency Syndrome (AIDS) or related disease....	<input type="checkbox"/>	<input type="checkbox"/>	24. Mental anxiety, emotional condition, or depression	<input type="checkbox"/>	<input type="checkbox"/>
3. Alcoholism or drug dependency.....	<input type="checkbox"/>	<input type="checkbox"/>	25. Muscular Disorders, Dystrophies.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Anemia, blood disease, or leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	26. Neurological disease or Parkinson's.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis or Rheumatoid Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	27. Neuritis, chronic or recurrent numbness/tingling.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma or chronic bronchitis.....	<input type="checkbox"/>	<input type="checkbox"/>	28. Obesity (overweight).....	<input type="checkbox"/>	<input type="checkbox"/>
7. Back trouble (recurrent or chronic).....	<input type="checkbox"/>	<input type="checkbox"/>	29. Prostate or male disorder.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer or tumor	<input type="checkbox"/>	<input type="checkbox"/>	30. Rectal disorder, hemorrhoids, or bleeding	<input type="checkbox"/>	<input type="checkbox"/>
9. Confusion or Alzheimer's.....	<input type="checkbox"/>	<input type="checkbox"/>	31. Sciatica or chronic pain	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	32. Skin condition or disease, melanoma.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Dizziness or headaches (frequent).....	<input type="checkbox"/>	<input type="checkbox"/>	33. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
12. Epilepsy or convulsions.....	<input type="checkbox"/>	<input type="checkbox"/>	34. Stomach disorders, frequent or chronic heartburn.....	<input type="checkbox"/>	<input type="checkbox"/>
13. Ear, nose, or throat disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	35. Thyroid or glandular	<input type="checkbox"/>	<input type="checkbox"/>
14. Eye disorder, glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	36. Ulcer (stomach or duodenal).....	<input type="checkbox"/>	<input type="checkbox"/>
15. Female disorders, fibroids, or excessive or irregular bleeding.....	<input type="checkbox"/>	<input type="checkbox"/>	37. Varicose veins, phlebitis, or blood clots.....	<input type="checkbox"/>	<input type="checkbox"/>
16. Gallbladder	<input type="checkbox"/>	<input type="checkbox"/>	38. Any other condition or disease not listed... above (list below)	<input type="checkbox"/>	<input type="checkbox"/>
17. Heart or circulatory.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
18. High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____		
19. Intestines, bowel, or colon.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
20. Joint problems, including knee and other	<input type="checkbox"/>	<input type="checkbox"/>	_____		
21. Kidney or bladder.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		
22. Liver disorder or hepatitis.....	<input type="checkbox"/>	<input type="checkbox"/>	_____		

SECTION 5 - HEALTH STATEMENT (continued)

Please explain below any items that you checked "Yes" on the previous page.

Question Number	Year	Duration	Name and Nature of Injury, Disease, or Condition	Was Recovery Complete?	Name and Address of Physician

B. Have you been advised to have an operation that was not performed? Yes No
 If "yes", please give full details, including name and address of physician _____

C. Have you been hospitalized in the last 5 years or are you currently hospitalized or in an extended care facility? Yes No
 If "yes", please explain below (use an extra sheet of paper if necessary).

Date of Hospitalization	Disease, Injury, or Condition	Name of Operation Performed, if any	Name and Address of Physician

D. Are you planning to be hospitalized within the next 6 months? Yes No
 If "yes", please explain _____

E. Have you taken any prescription medications within the past 12 months? Yes No
 If "yes", please explain below (use an extra sheet of paper if necessary).

Medication	Prescribing Physician	Medical Condition	Still Taking?

SECTION 6 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (complete only if billing should be sent to an address other than the Residence Street Address listed on the front of the application.)

Name	Relationship to Applicant
------	---------------------------

Address	City, State, ZIP Code
---------	-----------------------

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing). A discount for premium invoice payment quarterly, semi-annually, annually, or monthly by SurePay is available. Please contact our Sales Department at 1-866-704-2708 for further details.

- Monthly Billing Annually
- Quarterly Billing Semi-annually
- Surepay (monthly automatic bank deduction)

Note: If selecting Surepay, please fill out the information below.

SUREPAY is a simple and convenient way to keep your health coverage in force. If you select the SUREPAY option of paying for your Asuris Northwest Health health insurance the payment will be deducted automatically on the draft date you choose below. This will provide several advantages to you:

- ♦ Your payment will always be made on time (if funds are available in your account).
- ♦ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ♦ Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- ♦ Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY by mail or phone:

1. **Complete**, date and sign the Surepay Authorization information below.
2. **Write** "void" on one of your checks and return your "voided" check with this application (not a deposit slip). *For savings account please provide proof of ownership of the account.*

SUREPAY AUTHORIZATION

Please indicate which day you want your payment made.

- 5th of the month** - will pay the current month's charges
- 15th of the month** - will pre-pay the next month's charges
- 25th of the month** - will pre-pay the next month's charges

AUTHORIZATION TO MY BANK

- Checking Account
- Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Asuris Northwest Health, Seattle, WA. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

<hr/> Account Holder's Name (please print)	<hr/> Account Holder's Authorized Signature(s) as it appears on bank records	<hr/> Date
--	---	------------

SECTION 7 - INSURANCE PRODUCER (AGENT) CERTIFICATION

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Asuris Northwest Health. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Asuris Northwest Health, and the other services your producer provides you. For more information, please contact your producer.

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Asuris Northwest Health. I have informed the applicant that the effective date of coverage is assigned only by Asuris Northwest Health and provided the Washington Disclosure Information required.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

- 1. List any other medical or health insurance policies sold to the applicant _____
- 2. List the policies still in force _____
- 3. List the policies sold in the past 5 years that are no longer in force _____

Producer Name (please print or type)	Producer Phone Number	Asuris Appointment Number
Producer's Signature (Required)		Date (Required)
X		

PRODUCER: COLLECT NO PREMIUM WITH APPLICATION

SECTION 8 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to sign and date the application below. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETENESS AND CORRECTNESS

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSES OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES, AND DENIAL OF INSURANCE BENEFITS. I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Asuris Northwest Health to enroll in their coverage. I understand that Asuris Northwest Health will rely on each answer in making coverage and rating determinations. If coverage is rescinded for fraud or intentionally misleading statements, Asuris Northwest Health will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Asuris Northwest Health in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Asuris Northwest Health. Asuris Northwest Health may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

SECTION 8 - CERTIFICATION, AUTHORIZATION AND SIGNATURE (continued)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- ◆ a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- ◆ a clinic, hospital, long-term care or other medical facility;
- ◆ any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- ◆ an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Asuris Northwest Health may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Asuris Northwest Health Consumer Privacy Notice. A copy is available on our Web site at www.asuris.com or by telephone request at **1 (800) 365-3155**.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

SIGNATURE

Signature of applicant*	Date
X	

*** If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print) _____

Relationship to Individual _____ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

Do not send payment with your application. We will bill you upon acceptance of your application.

Please return this application to:

**Asuris Northwest Health
1602 21st Avenue
P.O. Box 1107
Lewiston, ID 83501**

FOR OFFICE USE ONLY
