NON-GROUP MEDICARE SUPPLEMENT INSURANCE

APPLICATION FORM FOR OPEN ENROLLMENT AND CONVERSION

INSTRUCTIONS

- This is an application for Medicare Supplement Insurance underwritten by Group Health Incorporated, an EmblemHealth company (hereafter referred to as "EmblemHealth"). It may be used to apply for new enrollment, or change in type of coverage. This application may be used to apply for one of EmblemHealth's Medicare Supplement Insurance Plans.
- **EmblemHealth cannot sell you a Medicare Supplement Insurance Plan if:**
  - **you already have a Medicare Supplement policy in force and you do not desire to replace the existing policy; or**
  - **the Medicare Supplement policy would duplicate benefits to which you are entitled under a Medicare Advantage plan.**
- This application may be used to apply for OPEN ENROLLMENT OR CONVERSION. Open Enrollment applicants are persons who do not currently have EmblemHealth coverage. Conversion applicants are persons who are currently covered by an EmblemHealth group or direct payment plan for which they are no longer eligible. Please check the appropriate box in question 1 for Open Enrollment or Conversion. All applicants must be residents of New York State.
- **Return your completed application. Please do not submit payment with the application.** When the application is processed, an invoice will be sent to you, along with your completed application form for your records. Your identification card will be sent to you upon receipt of your payment. A schedule page addendum to your contract will also be sent to you at that time. Your contract will be effective on the date set forth on the schedule page.
- **All applicants must:**
  a. Complete the application statement, sign and date the application where indicated; and
  b. Check the appropriate boxes for the coverage you are applying for.
  c. Return completed application and certificate(s) of creditable coverage to:

     EmblemHealth
Sales Direct Pay – Medicare Supplement
55 Water Street, 4th Floor
New York, NY 10041-8190
- EmblemHealth Medicare Supplement Insurance is underwritten by Group Health Incorporated ("GHI"), an EmblemHealth company.

Group Health Incorporated (GHI), HIP Health Plan of New York (HIP), HIP Insurance Company of New York and EmblemHealth Services Company, LLC are EmblemHealth companies. EmblemHealth Services Company, LLC provides administrative services to the EmblemHealth companies.

PRINT IN INK

NON-GROUP APPLICATION FOR PERSONS ELIGIBLE FOR MEDICARE

Social Security No.			
1. I am applying for: (Check one box only. If you are not sure which applies to you, please see "Instructions"). ❑ Open Enrollment ❑ Conversion — My current EmblemHealth identification number is: ______________________________			
2. Applicant's Last Name	First Name	Middle Name	
3. Home Address		County	
City	State	ZIP Code	Care of
4. ❑ Male ❑ Female			
5. Date of Birth (Month/Day/Year):			
6. Telephone No.:			
7. Date you became eligible for Medicare:			

You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing coverage and decide if you need multiple coverage. 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 may 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.

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.

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).

Please respond to questions 8 through 14 below to the best of your knowledge or belief: (Please mark Yes or No below with an "X")

8. (1) Did you turn age 65 in the last 6 months? ❑ Yes ❑ No

(2) Did you enroll in Medicare Part B in the last 6 months? ❑ Yes ❑ No
If yes, what is the effective date? ____________________

9. 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 met your "Share of Cost," please answer NO to this question.) ❑ Yes ❑ No

(1) Will Medicaid pay your premiums for this Medicare supplement policy? ❑ Yes ❑ No

(2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
❑ Yes ❑ No

10. (1) If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave END DATE blank. START DATE ____________ END DATE ____________

(2) If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❑ Yes ❑ No

(3) Was this your first time in this type of Medicare Advantage plan? ❑ Yes ❑ No

(4) Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan? ❑ Yes ❑ No

11. (1) Do you have another Medicare supplement or Medicare Select policy or certificate in force? ❑ Yes ❑ No

(2) If so, with what company, and what plan do you have? ____________________
____

(3) If so, do you intend to replace your current Medicare supplement or Medicare Select policy or certificate with this policy or certificate? ❑ Yes ❑ No

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

(1) If so, with what company, and what kind of policy?
____
____
____

(2) What are your dates of coverage under the other policy? (If you are still covered under the policy, leave END DATE blank.) START DATE ____________ END DATE____________

(3) Do you intend to replace the coverage(s) you identify in this item 12 above with this Medicare supplement policy or certificate? ❑ Yes ❑ No

13. I am applying for the following EmblemHealth Medicare Supplement Insurance Plan: (Check the appropriate box.)

❑ **Plan A** ❑ **Plan B** ❑ **Plan C** ❑ **Plan F** See enclosed disclosure statement for the applicable rates.
I hereby apply for coverage of the type checked above. Do not send a premium payment with this application. When this application is processed, we will bill you for the premium. Coverage is contingent upon our receipt of the premium.

14. If you are replacing any in force coverage with this Medicare supplement policy or certificate, what is the reason you are replacing the coverage:

❑ 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 due to:____________
____________________.
❑ Other: (please explain) ____________________.

The EmblemHealth Medicare Supplement Insurance Plans impose a pre-existing condition limitation. If you have a pre-existing condition, that condition generally is not covered for the first six (6) months after the effective date of coverage under the EmblemHealth Medicare Supplement Insurance Plan. A pre-existing condition is any condition for which medical advice was given or treatment was recommended by or received from a physician, within six (6) months prior to the effective date of coverage.

In applying the pre-existing condition limitation, EmblemHealth will credit the time you were previously covered under creditable coverage if the previous creditable coverage was continuous to a date not more than sixty-three (63) days prior to the enrollment date of the new coverage. EmblemHealth will reduce the period of the pre-existing condition limitation by the aggregate of the period of creditable coverage without regard to the specific benefits covered during the period. Creditable coverage includes: a group health plan; health insurance coverage; Medicare; Medicare supplement insurance; Medicare select coverage; Medicare Advantage plan; Medicaid; CHAMPUS; TRICARE; medical programs of the Indian Health Service or a tribal organization; a State health benefits risk pool; Federal Employees Health Benefits Program; a public health plan; and a health benefit plan under Section 5(e) of the Peace Corp Act.

I represent and understand that:

A. The contract applied for will have the Effective Date specified on the contract schedule page. On that date, my existing Medicare Supplement or Medicare Advantage coverage, if any, shall be cancelled.

B. All statements and answers in this application are true upon knowledge and belief. This application will be made part of the contract which will become effective on the date specified on the contract schedule page.

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR THE TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a criminal penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Name: ________________ **Signature:** ________________

Title: ________________ **Date:** ________________

General Agency	❑ To be Credentialed
GA No.	Override: %
Agent Name	
Address	
Telephone No.	
Fax	
GA Authorized Signature	

Selling Agent	❑ To be Credentialed
SA No.	Commission: %
Agent Name	
Address	
Telephone No.	
Fax	
Date	

(For EmblemHealth Office Use Only)

Type of Enrollment:	Open Enrollment	Conversion Initials
Date Application Issued		
Date Application Received		
Date Application Processed		
Date, Contract and Copy of Application Sent		
Type of Plan		
Group Number		
Category Number		
Effective Date		