



Medigap Application

1. Applicant Information			
Name (First, Middle Initial, Last)		Birthdate (MM/DD/YY):	
SSN #: / /	Medicare Claim Number or HIC Number:		
Medicare Part A Effective Date (MM/DD/YY):		Is this your proposed effective date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medicare Part B Effective Date (MM/DD/YY):		Is this your proposed effective date? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Age:	Height:	Weight:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Residence Address:			
City:	State:	Zip:	County:
Phone Number:		Email (optional):	
Alternative Mailing Address:			
City:	State:	Zip:	County:
Plan Applied For: <input type="checkbox"/> A <input type="checkbox"/> C <input type="checkbox"/> F <input type="checkbox"/> G		Effective Date Requested (MM/DD/YY):	
Person to Notify in Case of Emergency:			
Address:			
Phone Number:		Relationship to Applicant:	
Have you used tobacco in any form in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No			

2. Payment Information	
Payment Timing: <input type="checkbox"/> Monthly (EFT or credit card only) <input type="checkbox"/> Quarterly	Payment Mode: <input type="checkbox"/> EFT <input type="checkbox"/> Credit Card <input type="checkbox"/> Bill
Amount of Initial Premium Payment: \$	Initial Premium Payment Mode: <input type="checkbox"/> Check <input type="checkbox"/> Credit Card

3. Current/Replacement Coverage Questions					
<p>If you lost or are losing other health insurance coverage and received notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have 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 you received from your prior insurer with your application.</p> <p>PLEASE ANSWER ALL QUESTIONS BELOW:</p>					
A.	To the best of your knowledge; Did you turn age 65 in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you enroll in Medicare Part B in the last 6 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is your Medicare Part B effective date? (MM/DD/YY):				
B.	If you had coverage from any Medicare plan other than Original Medicare within the past 6 months (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), please fill in your start and end dates below. If you are still covered under this plan, leave "End Date" blank. If you are still covered under the other Medicare plan, do you intend to replace your current coverage with this Medicare supplement policy? <input type="checkbox"/> Yes <input type="checkbox"/> No Was this your first time in this type of Medicare plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Did you drop a Medicare supplement policy to enroll in this Medicare plan? <input type="checkbox"/> Yes <input type="checkbox"/> No Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud? <input type="checkbox"/> Yes <input type="checkbox"/> No	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%; border: none;"></td> <td style="width: 20%; border: none;">Start Date: MM/DD/YY</td> <td style="width: 20%; border: none;">End Date: MM/DD/YY</td> </tr> </table>		Start Date: MM/DD/YY	End Date: MM/DD/YY
	Start Date: MM/DD/YY	End Date: MM/DD/YY			

3. Current/Replacement Coverage Questions

	Do you have another Medicare supplement policy in force? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If so, with what company and what plan do you have?	
	Company Name:	Kind of Policy:
	Policy/Certificate Number:	Issue Date:
	Do you intend to replace your current Medicare supplement policy with this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, indicate termination date: (MM/DD/YY)	
C.	Have you had coverage under any other health insurance within the past 6 months? (For example: an employer, union, or individual plan) <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If so, what company and what kind of policy?	
	Company Name:	Kind of Policy:
	What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End Date" blank.)	Start Date: MM/DD/YY End Date: MM/DD/YY
	Has your coverage under a previous policy been involuntarily terminated for reasons other than nonpayment of premiums or for fraud? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D.	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. <input type="checkbox"/> Yes <input type="checkbox"/> No	
	If yes, will Medicaid pay your premiums for this Medicare supplement policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? <input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Health Questions

You do not need to complete this section if you are in your Medigap open enrollment period or a guaranteed issue period. Please go to Section 5.

If you are not in your Medigap open enrollment period or a guaranteed issue period, please answer all questions to the best of your knowledge. If you answer "yes" to any of the following questions, you are not eligible for coverage.

A.	Are you currently bedridden, or are you currently hospitalized, admitted to a nursing facility, or other care facility, or do you need the assistance of a walker or wheelchair? <input type="checkbox"/> Yes <input type="checkbox"/> No
B.	Has admission to a hospital, nursing facility or other care facility been recommended by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No
C.	Has the use of a walker or wheelchair been prescribed to you by a health care professional? <input type="checkbox"/> Yes <input type="checkbox"/> No
D.	In the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? <input type="checkbox"/> Yes <input type="checkbox"/> No
E.	Within the past 2 years, have you been hospitalized 2 times or more, or been confined to a nursing home for 2 weeks or longer? <input type="checkbox"/> Yes <input type="checkbox"/> No
F.	Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (included drug therapy) or been hospitalized for: cancer (except basal cell), leukemia, Hodgkin's disease, coronary artery disease, heart attack, nephritis, kidney failure (or any form of kidney disease), stroke, or brain disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
G.	Within the past 5 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (included drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery, or angioplasty, organ transplant (except cornea), chronic renal failure, polycystic kidney disease (or any form of kidney disease), cirrhosis of the liver or complications of diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No
H.	If I am completing this application online, I acknowledge that I understand that I have opted in for all communication regarding the status of this application, including formal application acceptance or denial, to be sent to me via the e-mail address provided during the online application process. <input type="checkbox"/> Yes <input type="checkbox"/> No

5. Please read this Important Information

A.	You do not need more than one Medicare supplement policy.
B.	If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
C.	You may be eligible for benefits under Medicaid or may not need a Medicare supplement policy.
D.	If after purchasing the 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.
E.	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.
F.	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).

6. Please read and sign below

A.	I am applying for a Medicare supplement policy. My answers and statements on this application are true and complete. I understand that upon acceptance of the completed application, I will receive my policy. I understand my policy will not become effective until I am eligible for Medicare, my first month premium has been received and my application has been approved by Rocky Mountain Health Plans (RMHP).
B.	It is unlawful to provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denials of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.
C.	RMHP has the right to reject my application. If my application is rejected, I will be notified in writing and any application fees submitted with the application will be refunded. I understand and agree that if RMHP rejects my application, under no circumstances will any RMHP benefits be payable. Cashing of my check by RMHP does not constitute approval of my application.
D.	If my application is accepted, this application will become part of the agreement between RMHP and myself. If this application is accepted, I further agree to be bound by the arbitration clause set forth in this application and I waive my right to court trial by judge or jury in the event of any dispute arising under this policy.
E.	RMHP may request additional information, which may delay processing of this application. If the health care provider bills for this information, I understand that I will be responsible for the amount.
F.	The selling agent has no authority to promise me coverage or to modify RMHP underwriting policy or terms of any RMHP coverage.
G.	I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted and that RMHP may void all coverage from the original effective date of this policy only in the event that I failed to accurately respond to questions regarding my past or present health conditions.

7. Authorization & Agreement

- **Protected Health Information (PHI) to be Used and/or Disclosed:** Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for Alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome), or ARC (AIDS-related complex), but not including psychotherapy notes.
- **Entities or Persons Authorized to Use or Disclose:** U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.
- **Entities or Persons Authorized to Receive:** Rocky Mountain Health Plans or affiliate (“RMHP”), its agents, employees, designees, representatives, including my RMHP agent or broker, for the purpose(s) described below.
- **Purpose of this Authorization:** By signing this form, you will authorize RMHP to use and/or disclose your PHI to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.
- **Effect of Declining:** If I decide not to sign this authorization, RMHP may decline to enroll me in their health plan. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.
- **Expiration:** This authorization will expire upon termination of any RMHP coverage that may be in effect.
- **Right to Revoke:** I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Rocky Mountain Health Plans, PO Box 10600, Grand Junction, CO 81502-5600.
- I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my PHI, as described in this authorization. A photocopy of this authorization is valid as the original, and I and my RMHP agent or broker are entitled to receive a copy of this form. I AM ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER I SIGN IT.

Print Applicant's Name:	
Applicant's Signature:	Date (MM/DD/YY):
If the authorization is signed by a personal representative, on behalf of the individual, complete the following:	
Print Personal Representative's Name:	
Personal Representative's Signature:	Date (MM/DD/YY):
Relationship to Applicant:	
Name of the other person or persons authorized to receive my PHI:	
Name of the other person or persons authorized to use or disclose my PHI:	
Agent Name:	
Agency:	
Address:	
Phone#:	

**Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage
 Rocky Mountain Health Plans: PO Box 10600, Grand Junction, CO 81502-5600**

Save this notice! It may be important to you in the future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Rocky Mountain Health Plans. Your new policy will provide thirty (30) days within which you may decide – without cost – whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to the Applicant by Issuer, Agent, Broker, or other Representative.

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D
- I am disenrolling from a Medicare Advantage plan (please explain reason for disenrollment): _____
- No change in benefits, but lower premiums
- Other (please specify): _____

Important Information

- Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under this new policy. This could result in denial or delay of a claim for benefits under this new policy, whereas a similar claim might have been payable under your present policy.
- State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. Rocky Mountain Health Plans will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under your original policy.
- If you still wish to terminate your present policy 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 Rocky Mountain Health Plans to deny any future claims and to refund your premium as though your policy had never been in force. After your 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 receive your new policy and are sure that you want to keep it.

 Applicant's Signature

 Signature of agent/broker/representative

 Print Name of Applicant

 Print Name of Agent or Broker

Date: _____

Agent or Broker's Address: _____



Acknowledgement of Receipt of Information

Applicant please sign and submit with application.

I have received the Outline of Coverage for the policy applied for.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I have received the required Guide to Health Insurance for People with Medicare.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand that my broker (if applicable) is responsible for sending me hard copy notice of acceptance or denial of this application.

Print Applicant's Name:	
Applicant's Signature:	Date (MM/DD/YY):
If the authorization is signed by a personal representative, on behalf of the individual, complete the following:	
Print Personal Representative's Name:	
Personal Representative's Signature:	Date (MM/DD/YY):
Relationship to Applicant:	

Broker please sign and submit with application.

1) Have you sold any other policies to this individual which are still in force? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please submit documentation with application)	
2) Have you sold any policies to this individual in the last five (5) years that are not still in force? <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please submit documentation with application)	
Broker's Signature:	Date (MM/DD/YY):