HEALTH TRADITION

Proposed Effective Date:_____

Health Tradition 65Plus Platinum Application

Special Notes

- You do not need more than one Medicare supplement, Medicare cost or Medicare Select policy.
- If you purchase this policy, you may want to evaluate any other existing healthcare coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Select policy.
- If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Select policy can be suspended, if requested, for a total of 24 months during your entitlement to benefits under Medicaid. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended 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 you are eligible for and have enrolled in a Medicare Select 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 Select policy can be suspended, if requested, while you are covered by the employer or union-based group health plan. If you suspend your Medicare Select policy for this reason and then lose coverage under the group health plan, your Medicare Select policy may be reinstated effective as of the date you lost coverage under the group health plan. To reinstate your Medicare Select policy, you must:
  - Provide notice of loss of coverage under the group health plan within 90 days of the date you lost coverage and;
  - Pay the premium for the period effective as of the date of loss of the employer or union-based coverage.
- Counseling services are available to provide advice concerning your purchase of a Medicare Select policy 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). See the booklet Wisconsin Guide to Health Insurance for People with Medicare which you received at the time you were solicited to purchase this policy.
- Guarantee issue – Medicare Select issuers must guarantee issue certain basic Medicare Select policies to eligible individuals. This means that Health Tradition cannot discriminate in the pricing of such a policy because of health status, claims experience, receipt of healthcare, medical condition or age, and cannot impose a pre-existing condition exclusion. To determine if you are eligible for guarantee issue of this plan, please complete the questions in Section II.
- We do not request, require or purchase genetic information prior to any person's enrollment in this policy in connection with such enrollment, or for use in underwriting.

Section I – Please fill in completely.

I hereby apply for Health Tradition 65Plus Platinum, a Medicare Select policy.

Applicant's Full Name – First, Middle, Last | Date of Birth Month Day Year

Permanent Physical Address | County

City | State | Zip Code

Mailing Address (if different from permanent address)

City | State | Zip Code

Social Security Number | Gender ☐ Male ☐ Female | Home Phone Number

Marital Status
☐ Married ☐ Single ☐ Divorced ☐ Widowed

Are you enrolled in Federal Medicare?
Part A – Hospital ☐ Yes ☐ No
Part B – Medical ☐ Yes ☐ No

Medicare Identification Number (MBI) _____
Effective date: Month _____ Day _____ Year _____
Effective date: Month _____ Day _____ Year _____

Section II – Please answer all questions.

If you lost or are losing other health insurance coverage and received a notice from your prior insurance company saying that you were eligible for guaranteed issue of a Medicare supplement or select insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in our Medicare Select plan. Please include a copy of the notice from your prior insurance company with your application.

1. Are you in your open enrollment period? ☐ Yes ☐ No

   You are in your open enrollment period for six (6) months following:

   - The first month during which you first enroll in Medicare Part B; or
   - The beginning of the month in which you turned 65

   a. Requested effective date for 65Plus Platinum policy: _____

2. 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 met your "Share of Cost", please answer NO to this question.

   If yes,

   a. Will Medicaid pay your premiums for this Medicare Select policy? ☐ Yes ☐ No

   b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Yes ☐ No

3. a. 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 health maintenance organization or preferred provider organization)? ☐ Yes ☐ No
   If yes, fill in your start and ends dates below.

   START ___ / ___ / ___ END ___ / ___ / ___ (If you are still covered under this plan, leave "END" blank.)

   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new 65Plus Platinum Medicare Select Policy? ☐ Yes ☐ No

   c. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   d. Did you drop a Medicare Supplement or Medicare Select policy to enroll in the Medicare plan? ☐ Yes ☐ No

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

   b. If yes, with what company and what plan do you have?

      ☐ Medicare Select Plan

      ☐ Medicare Supplement

      Company _____

   c. If yes, do you intend to replace your current Medicare Supplement or Select policy with this policy? ☐ Yes ☐ No

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

   a. If so, with what company and what kind of policy?

      Company _____ Kind of Policy _____

      Phone Number of Insurance Company: _____

      Your Identification and Group Number with Insurance Company: _____

   b. What are your dates of coverage under the other policy?

      START ___ / ___ / ___ END ___ / ___ / ___ (If you are still covered under this plan, leave "END" blank.)

Section III – Please complete this section ONLY if you are NOT in your open enrollment period.

STATEMENT OF HEALTH

NOTE TO APPLICANT: If you are applying within your open enrollment period or applying under guarantee issue, do not complete this section. If you answered yes to Question 1 in Section II, please skip to Section IV.

1. Current height: _____ feet _____ inches Weight: _____lbs.

Do you:

2. Drink alcoholic beverages? ☐ Yes ☐ No
   If yes, number of occasions per week? _____
   Type and number of drinks on each occasion? _____
3. Smoke cigarettes? ☐ Yes ☐ No
   If yes, how many packs per day? _____ How many years smoking? _____
4. Are you currently bedridden or confined to a wheelchair? ☐ Yes ☐ No
5. To the best of your knowledge and belief, have you in the past 5 years been treated for or had any indication of (genetic test results need not be revealed):
   a. Heart attack or heart surgery, angina, high blood pressure, or other disease of the heart or blood vessels? ☐ Yes ☐ No
   b. Nervous or mental disorder, Alzheimer's disease, paralysis, stroke, headaches, seizures or migraines? ☐ Yes ☐ No
   c. Emphysema or other respiratory disease? ☐ Yes ☐ No
   d. Ulcer, hernia, intestinal bleeding, or other disease of the stomach or intestines? ☐ Yes ☐ No
   e. Disease of the kidneys, bladder, the urinary tract, and (if applicable) disease of the prostate, breast, uterus? ☐ Yes ☐ No
   f. Diabetes or disease of the liver or gall bladder? ☐ Yes ☐ No
   g. Cancer, tumor or transplant? ☐ Yes ☐ No
      What type? _____
   h. Phlebitis, varicose veins, anemia, or other disease of the blood? ☐ Yes ☐ No
   i. Arthritis or other disease of muscles, bones, back, joints? ☐ Yes ☐ No
   j. Treatment for alcoholism or drug abuse? ☐ Yes ☐ No
   k. Cataract or other disease of the eyes? ☐ Yes ☐ No
      If yes, is vision affected? ☐ Yes ☐ No
      When diagnosed? _____ (year)
      Is surgery contemplated? ☐ Yes ☐ No
      Has surgery been completed? ☐ Yes ☐ No Date _____ (year)

   Give details to questions 5a-5k which are answered "yes" including dates, names and locations of physicians consulted, conditions, degree of recovery.

   _____

   _____

   _____

   _____

6. During the past five (5) years, have you been advised to have any diagnostic tests, hospitalizations, or inpatient or outpatient surgeries that have been scheduled or completed? ☐ Yes ☐ No
   (You do not have to reveal the results of an AIDS test at an anonymous counseling and testing site, home test kits, or genetic tests.)
   If yes, clarify. _____

   _____
7. Have you been hospitalized during the past year? ☐ Yes ☐ No
8. Are you currently confined to a nursing home or contemplate confinement in the next 12 months? ☐ Yes ☐ No

9. List below all visits to or by a physician and hospitalizations in the past five (5) years starting with most recent. (If no visits or hospitalizations, write "None".)

Date	Physician or Hospital	City, State, Zip Code	Reason

10. List medication(s) you take regularly and condition(s) for which they are taken.

Medication Name and Dosage	Condition

Section IV – Please read and sign below.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Instructions: Please read this authorization section carefully before signing. Your application cannot be processed without a signature for the person seeking coverage. Signing this section is a condition of coverage: if you decide not to sign, you will not be enrolled in Health Tradition Health Plan's (HTHP) 65Plus Platinum. You have the right to receive a copy of this section after you complete and sign it.

I. Protected Health Information

By signing this form, I authorize HTHP to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, lab results, mental health records, and alcohol and/or drug abuse records. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes or the disclosure of information concerning whether I have obtained a test for the presence of HIV antigen or nonantigenic products of HIV or an antibody to HIV or what the results of this test were.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of preenrollment underwriting or risk-rating of health insurance coverage for me, to determine eligibility for enrollment or benefits under a health plan, or to allow the insurer to conduct utilization review and quality improvement activities per our Notice of Privacy Practices ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize HTHP, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above.

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, insurance intermediaries, or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, healthcare provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc., consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me to give to HTHP any and all protected health information about me, to be covered concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal trait, and mode of living, including, but not limited to, all medical and healthcare records, but not including whether I obtained a test for the presence of HIV antigen or nonantigenic products of HIV or what the results of this test were.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws per our Notice of Privacy Practices.

IV. Term of Authorization

I agree this Authorization shall be valid for two (2) years from the signature date below.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to HTHP. Revocation of this authorization form will not affect actions HTHP or others took in reliance on this form prior to the written notice of revocation.

I have had full opportunity to read and consider this form. I understand that, by signing this form, I authorize the uses and disclosures of protected health information described in this form. I understand that I may only revoke authorization for myself consistent with state law.

I certify that the information I have provided on this form is both accurate and complete. I understand that intentionally omitting or providing false/misleading information on an insurance application or an insurance claim is a crime, and may result in the loss of benefits issued.

_____
Signature of Adult Applicant

_____
Date Signed

_____
Printed Name

_____
Agent Name/Agency (if applicable)

HEALTH TRADITION

HEALTH TRADITION
HEALTH PLAN 65Plus Platinum

45 Nob Hill Road • Madison, WI 53713

Notice to Applicant Regarding Replacement of Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident and Sickness Insurance

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

According to your application, you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a Medicare Select policy to be issued by Health Tradition Health Plan. With your new policy you are allowed thirty (30) days to 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. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy. Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

Statement to applicant by issuer, agent, broker or other representative:

☐ I am replacing my current Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident & Sickness Insurance.

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Select policy will not duplicate your existing Medicare Supplement, Medicare cost, Medicare select or Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare cost, Medicare select coverage or leave your Medicare Advantage plan.

The replacement policy is being purchased for the following reason(s):

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

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing condition waiting periods. The insurer will waive any time periods applicable to pre-existing conditions waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.

3. 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 requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

☐ I am NOT replacing my current Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident & Sickness Insurance.

_____ _____
Signature of Agent, Broker or Other Representative | Applicant's Signature

_____ _____
Typed Name and Address of Issuer, Agent or Broker | Date

White Copy - Return with application *Yellow Copy – Retain for your records*

HEALTH TRADITION

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HEALTH PLAN 65Plus Platinum

45 Nob Hill Road • Madison, WI 53713

Acknowledgement of Receipt of Outline of Coverage, OCI Brochure, Provider Directory, and Notice of Medicare Select Policy Restrictions

The undersigned hereby acknowledges that he/she has been given and received a copy of the documents listed below:

1. Outline of Coverage which includes a description of:
   - Coverage of non-network providers
   - In-area emergency and urgent care
   - Out-of-area emergency and urgent care
   - Limitations on referral care
   - Quality assurance program
   - Grievance procedure
2. "Wisconsin Guide to Health Insurance for People with Medicare" brochure published by the Wisconsin Office of the Commissioner of Insurance
3. Provider Directory

I further understand that this Medicare Select Policy has restrictions as to the providers a subscriber may use for non-emergency care (see provider directory enclosed). To continue as a subscriber under this Medicare Select Policy, I understand that I must live in the Plan's service area at least 245 days of each calendar year.

_____ _____

Signature Date

White Copy - Return with application
Yellow Copy - Applicant, retain for your records