HEALTH TRADITION

Proposed Effective Date:_____

Health Tradition 65Plus Premier 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 your other existing health care coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement, Medicare Cost or Medicare Select policy.
- If after purchasing this policy you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement, Medicare Cost or Medicare Select policy can be suspended, if requested, for 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 Medicare Select 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 Select 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 suspension.
- If you are eligible for and have enrolled in a Medicare Supplement, Medicare Cost or 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 Supplement, Medicare Cost or 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 Supplement, Medicare Cost or Medicare Select policy under these circumstances and later lost your employer or union-based group health plan, your suspended Medicare Supplement, Medicare Cost or Medicare Select 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, Medicare Cost or Medicare Select 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 suspension.
  To reinstate your Medicare Select policy, you must:
  1. Provide notice of loss of coverage under the group health plan within 90 days of the date you lost coverage and;
  2. Pay the premium for the period effective as of the date of loss of the employer or union-based coverage.
- Counseling services are available in your state to provide advice concerning your purchase of a Medicare Supplement, Medicare Cost or 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 health care, 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.

FOR INTERNAL USE ONLY

Network:_____

Rating Area: _____

Section I – PLEASE FILL IN COMPLETELY.

I hereby apply for Health Tradition 65Plus Premier, 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)	
Social Security Number	Gender ☐ Male ☐ Female / Home Phone Number
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed	Email Address

Are you enrolled in 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 insurer 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. **Please mark Yes or No below with an X.**

To the best of your knowledge,

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 Premier 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 Premier 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

   ☐ 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: _____ (ft./in.) Current weight: _____ (lbs.)
2. Have you used any form of tobacco, an electronic cigarette or other Nicotine products in the past 12 months? ☐ Yes ☐ No
3. Are you currently bedridden or confined to a wheelchair? ☐ Yes ☐ No
4. Do any of these apply to you:
   a. Have end stage renal (kidney) disease ☐ Yes ☐ No
   b. Diagnosed with kidney disease for which you are currently receiving dialysis or have been recommended to receive dialysis ☐ Yes ☐ No
   c. Diagnosed with or treated or awaiting test results for internal cancer, leukemia, lymphoma or melanoma within the past 24 months ☐ Yes ☐ No
   d. Admitted to the hospital as an inpatient within the past 24 months ☐ Yes ☐ No
   e. Use insulin for diabetes ☐ Yes ☐ No
   f. Take prescription drugs for both diabetes and a heart condition (excluding high blood pressure) ☐ Yes ☐ No
   g. Take an anti-coagulant (blood thinner) medication ☐ Yes ☐ No
   h. Use oxygen as a treatment for a diagnosed medical condition ☐ Yes ☐ No
   i. Within the past 24 months received drugs administered by intravenous (IV) infusion, other than during an emergency room visit or inpatient hospitalization ☐ Yes ☐ No
5. Are you currently or have you been hospitalized or confined to a nursing home or residing in an assisted living facility within the past 90 days, or contemplate confinement in the next 12 months or have you been hospitalized two or more times in the past 12 months? ☐ Yes ☐ No
6. Have you had or been recommended to have an organ or stem cell transplant (excluding corneal transplants)? ☐ Yes ☐ No
7. Do you or have you been told by a medical professional that you have Alzheimer's Disease, Dementia or any other cognitive disorder? ☐ Yes ☐ No
8. Do you have a nervous or mental disorder, paralysis, headaches, seizures or migraines? ☐ Yes ☐ No
9. Have you received a positive diagnosis for AIDS or HIV* by a member of the medical profession? ☐ Yes ☐ No
   a. *The reporting of HIV test results is limited to only the results of FDA licensed tests. HIV test results received at an anonymous counselling and testing site need not be revealed.
10. Has a medical professional advised or discussed as a treatment option that you may need surgery (includes cataract surgery), drugs administered by intravenous (IV) infusion, use of oxygen or a non-routine medical procedure within the next 12 months? ☐ Yes ☐ No
11. Within the past 5 years, have you had, been treated for, or been told by a medical professional that you have any of the following:
    a. Alcoholism, drug addiction (or drug abuse) ☐ Yes ☐ No
    b. Congestive heart failure, valvular heart disease, coronary artery disease, heart rhythm disorder, heart attack, angina, heart surgery (includes bypass, balloon surgery or placement of an arterial stent), high blood pressure or other disease of the heart or blood vessels ☐ Yes ☐ No
    c. Systemic lupus erythematosus (SLE) ☐ Yes ☐ No
    d. Multiple sclerosis, Amyotrophic Lateral Sclerosis (ALS), Parkinson's Disease ☐ Yes ☐ No
    e. Fractures or amputation caused by disease, degenerative bone disease, severe arthritis involving the spine or major joints (hip, knee or shoulder) or other diseases of the muscles, bones, back, joints ☐ Yes ☐ No
    f. Liver or gallbladder disease, chronic kidney disorder, kidney failure, kidney dialysis ☐ Yes ☐ No
    g. Chronic obstructive pulmonary disease (COPD), emphysema, Chronic lung disease, Chronic bronchitis, a breathing disorder or other respiratory disease ☐ Yes ☐ No
    h. An illness or condition for which you use oxygen ☐ Yes ☐ No
    i. Stroke, transient ischemic attack (TIA) ☐ Yes ☐ No
    j. Ulcer, hernia, intestinal bleeding or other disease of the stomach or intestines ☐ Yes ☐ No
    k. Disease of the bladder, urinary tract and (if applicable) disease of the prostate, breast or uterus ☐ Yes ☐ No
    l. Phlebitis, varicose veins, anemia or other disease of the blood ☐ Yes ☐ No
    m. Cataract or other disease of the eyes ☐ Yes ☐ No
       i. If yes, is vision affected? ☐ Yes ☐ No
       ii. When diagnosed? _____

iii. Is surgery contemplated?..... ☐ Yes ☐ No
iv. Has surgery been completed?..... ☐ Yes ☐ No
1. Date:_____

n. Advised to have any diagnostic tests, hospitalizations or inpatient or outpatient surgeries that have been scheduled or completed..... ☐ Yes ☐ No

12. List below all visits to or by a physician and hospitalization in the past five (5) years starting with the most recent.

_____

_____

_____

_____

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

_____

_____

_____

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 Premier. 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, health care 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 health care 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

_____

Printed Name

_____

Agent Name/Agency (if applicable)

HEALTH TRADITION

HEALTH TRADITION HEALTH PLAN 65Plus

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. 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. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy. If, after due consideration, you find that the purchase of this Medicare Supplement, Medicare Cost, Medicare Select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare Supplement, Medicare Cost, Medicare Select or Medicare Advantage coverage.

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 and Sickness Insurance.

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement, Medicare Cost, Medicare Select, or, if applicable, Medicare Advantage policy will not duplicate your existing Medicare Supplement, Medicare Cost, Medicare Select or, if applicable, 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 premiums
☐ 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 preexisting 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 conditions, waiting periods, elimination periods or probationary periods. The insurer 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 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 and Sickness Insurance.

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

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

** Signature not required for direct response sales.*

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

HEALTH TRADITION

HEALTH TRADITION HEALTH PLAN 65Plus

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 s/he 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