MEDICARE SUPPLEMENT INSURANCE APPLICATION

PRINT IN INK **NON-GROUP APPLICATION STATEMENT FOR PERSONS ELIGIBLE FOR MEDICARE**

Social Security No.

1. I am applying for: (Check one box only.)
   ❑ Open Enrollment ❑ Conversion — My current GHI 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 become 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.

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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. The request must be in writing.

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).

8. To the best of your knowledge, do you have another Medicare Supplement Insurance policy Certificate in force
   ❑ Yes ❑ No If yes, please complete the information indicated below.

Name and Address of Insurer	Telephone No. of Insurer	Name of Policyholder	I.D. Number	Effective Date of Policy

9. To the best of your knowledge, do you have any other health insurance policies or certificates that provide benefits similar to this GHI Medicare Supplement Plan? ❑ Yes ❑ No

If yes, which plan(s)?			
	Hospital Insurance	❑ Yes	❑ No
	Medical Insurance	❑ Yes	❑ No
	Other	❑ Yes	❑ No
	(Please specify)		

With which company (please complete the information inidicated below)?

Type of Plan	Name and Address of Insurer	Telephone No. of Insurer	Name of Policyholder	I.D. Number	Effective Date of Policy
Hospital					
Medical					

Dental

Other (Please specify)

THE SALE OF A MEDICARE SUPPLEMENT POLICY TO AN INDIVIDUAL WITH SUCH A POLICY IN FORCE IS PROHIBITED EXCEPT WHERE THE INDIVIDUAL SEEKS TO REPLACE AN EXISTING MEDICARE SUPPLEMENT POLICY. REVIEW YOUR CURRENT HEALTH INSURANCE COVERAGE AND DETERMINE YOUR NEEDS BEFORE YOU PURCHASE THIS INSURANCE.

10. Do you intend to replace any current accident and health insurance policy or certificate presently in force with the GHI Medicare Supplement Insurance Plan you are now applying for? ❑ Yes ❑ No
    If yes, please identify the type of plan you intend to replace.

Medicare Supplement Insurance	❑ Yes	❑ No	Medical Insurance	❑ Yes	❑ No
If yes, was this policy issued by GHI?	❑ Yes	❑ No	Other	❑ Yes	❑ No
Hospital Insurance	❑ Yes	❑ No	Please specify:		

11. Please indicate the reason(s) you are replacing your existing policy. (Check all that apply.)
    ❑ Additional benefits ❑ No change in benefits, but lower premium ❑ Fewer benefits and lower premiums
    ❑ Other (please specify) ________________

12. Are you covered for medical assistance through the state Medicaid program?	❑ Yes	❑ No
(a) As a Specified Low Income Medicare Beneficiary (SLMD)?	❑ Yes	❑ No
(b) As a Qualified Medicare Beneficiary (QMB)?	❑ Yes	❑ No
(c) For other Medicaid medical benefits?	❑ Yes	❑ No
(d) Will Medicaid pay the premium for this policy?	❑ Yes	❑ No

13. I am applying for the following GHI Medicare Supplement Insurance Plan: (Check the appropriate box.)
    ❑ **Plan A** ❑ **Plan B** ❑ **Plan C** ❑ **Plan I** See enclosed sheet for the applicable rates.
    I hereby apply for coverage of the type checked above. When this application is processed, coverage will be effective only if payment of the premium is received in accordance with the bill.

I represent and understand that:

A. The contract applied for will have the Effective Date specified on the Identification Card. On that date, my existing GHI contract, if any, shall be cancelled except that any remaining waiting period of my existing GHI contract will apply to the new contract, up to maximum of six months.

B. Any physician, other practitioner, hospital or skilled nursing facility that has advised, treated, attended or rendered service to me or who has any information or service to me or who has any information or records with respect to me, is authorized and directed to provide all such information and records to you when necessary to process my claims.

C. 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 Identification Card.

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