Montana Health Co-Op
Medicare Supplement Administrative Office
P.O. Box 2209
Duncan, OK 73534-2209
Telephone: 800-366-8354

Application for **Medicare Supplement Insurance**

Issued by

Montana Health Co-Op
810 Hialeah Ct, Helena, MT 59601

MONTANA

Application for Medicare Supplement Insurance

- Type or Print clearly and use blue or black ink.
- If only one applicant, just complete **Applicant A** information.
- Complete all required sections of the application. Any incomplete or missing information could delay processing of your application.

☐ New Business
☐ Coverage Change

1 Applicant A Information

Write the name as stated on the Medicare card. Provide a copy of the Medicare card with the application if possible.

Full name of proposed insured *First, M.I., Last*

Address | Phone

City | State | Zip

E-mail | Social Security Number - -

Write the date of birth that is on the birth certificate.

Birth date *mm/dd/yyyy* | Age | ☐ Male ☐ Female

Height *Feet and inches* | Weight *Pounds*

Are you a legal resident of the United States? ☐ Yes ☐ No

Have you used any form of tobacco in the past 12 months including vaping or e-cigarettes? ☐ Yes ☐ No

Include any letters associated with the Medicare number and in the appropriate position. If applicant has not received a Medicare card yet, put "No Medicare number yet".

Medicare card number

Date enrolled in: Medicare Part A *mm/dd/yyyy* / / | Medicare Part B *mm/dd/yyyy* / /

Applicant B Information

Review instructions above before completing.

Full name of proposed insured *First, M.I., Last*

Address | Phone

City | State | Zip

E-mail | Social Security Number - -

Birth date *mm/dd/yyyy* | Age | ☐ Male ☐ Female

Height *Feet and inches* | Weight *Pounds*

Are you a legal resident of the United States? ☐ Yes ☐ No

Have you used any form of tobacco in the past 12 months including vaping or e-cigarettes? ☐ Yes ☐ No

Medicare card number

Date enrolled in: Medicare Part A *mm/dd/yyyy* / / | Medicare Part B *mm/dd/yyyy* / /

For Agent Use Only

Check if application is for:

Applicant A ☐ Open Enrollment ☐ Guaranteed Issue

Applicant B ☐ Open Enrollment ☐ Guaranteed Issue

Deliver: ☐ To Agent ☐ To Applicant(s) ☐ Electronically

2 Plan and Premium Information

Applicant A	**Applicant B**
Plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N	Plan selected: ☐ Plan A ☐ Plan F* ☐ Plan G ☐ Plan HDG ☐ Plan N

**Plan F available to those first eligible before 01/01/2020*

Requested Medicare Supplement effective date: *mm/dd/yyyy* / /	Requested Medicare Supplement effective date: *mm/dd/yyyy* / /
Payment mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT	Payment mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT

Modal Premium:	Modal Premium with Discount:	One-Time Policy Fee:	Total Premium:	Modal Premium:	Modal Premium with Discount:	One-Time Policy Fee:	Total Premium:
$	$	$ 25.00	$	$	$	$ 25.00	$

Initial Premium:	**Initial Premium:**
☐ Draft initial premium upon policy approval	☐ Draft initial premium upon policy approval
☐ Draft initial premium on policy effective date	☐ Draft initial premium on policy effective date

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

You have the option of selecting either a specific date, or a specific week and day for the draft to occur each month:
If you want your draft to occur on a **specific date**, please enter a date (between 1st and 28th)

Specific Draft Date: / /	Specific Draft Date: / /

For drafts occurring on a **specific day and week** you **must** select what week and day the draft should occur:

Select the week each month: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th	Select the week each month: ☐ 1st ☐ 2nd ☐ 3rd ☐ 4th
Select the day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday	Select the day of the week: ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

BANK ACCOUNT INFORMATION (Check appropriate box)

☐ Checking Account ☐ Savings Account	☐ Checking Account ☐ Savings Account
Name of Financial Institution and City	Name of Financial Institution and City
Transit No. & Routing	Transit No. & Routing

APPLICANT INFORMATION FOR FINANCIAL INSTITUTIONS:

As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Montana Health Co-Op provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT INFORMATION FOR MONTANA HEALTH CO-OP:

It is understood that the drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract, and no other notice of premiums due will be given. No premium shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium payment has been received by Montana Health Co-Op. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by Montana Health Co-Op if any draft is not paid upon presentation. The payment of premiums under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Montana Health Co-Op upon 30 days written notice.

Print name as it appears on account	Print name as it appears on account
Signature of depositor Date	Signature of depositor Date

Household Premium Discount Eligibility Information

Applicant:	A	B
	☐ Y ☐ N	☐ Y ☐ N

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

A. For the past year, have you continuously resided with your spouse, including validly recognized civil union and domestic partners, or at least one, but no more than three, other individuals?

B. If you answered "YES" to Question 1 above, please fill out the following information about the household resident, unless both applicants are applying for coverage on this application.

Full name *First, M.I., Last* Montana Health Co-Op Policy Number

Address City State Zip

Full name *First, M.I., Last* Montana Health Co-Op Policy Number

Address City State Zip

Full name *First, M.I., Last* Montana Health Co-Op Policy Number

Address City State Zip

3 Eligibility Questions

Please answer all questions.

NOTE: You may be eligible for guaranteed issue of a Medicare Supplement insurance policy, please refer to "A Guide to Health Insurance for People with Medicare" for more details on guaranteed issue eligibility. You may qualify for Medicare if you are under the age 65 and disabled.

NOTE: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to question 2.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had 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 from your prior insurer with your application.

To the best of your knowledge: **Applicant:** **A** **B**

1. Did you turn age 65 in the last 6 months? ☐ Y ☐ N ☐ Y ☐ N
   - A. Did you enroll in Medicare Part B in the last 6 months? ☐ Y ☐ N ☐ Y ☐ N
   - B. Did you enroll in Medicare Part C in the last 6 months? ☐ Y ☐ N ☐ Y ☐ N
   - C. Did you enroll in Medicare Part D in the last 6 months? ☐ Y ☐ N ☐ Y ☐ N
   - D. If yes, what is the effective date?

	Applicant A effective date	**Applicant B** effective date
Part B	/ /	/ /
Part C	/ /	/ /
Part D	/ /	/ /

2. Are you covered for medical assistance through the state Medicaid program? ☐ Y ☐ N ☐ Y ☐ N
   - A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Y ☐ N ☐ Y ☐ N
   - B. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Y ☐ N ☐ Y ☐ N

3. If 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 HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.

	Applicant A start date	End date
	/ /	/ /
Applicant B start date	/ /	/ /

   - A. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Y ☐ N ☐ Y ☐ N
   - B. Was this your first time in this type of Medicare plan? ☐ Y ☐ N ☐ Y ☐ N
   - C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Y ☐ N ☐ Y ☐ N

4. Do you have another Medicare Supplement policy inforce? ☐ Y ☐ N ☐ Y ☐ N
   - A. If so, with what company, and what plan do you have?

	Applicant A - Company	Plan
Applicant B - Company		Plan

   - B. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Y ☐ N ☐ Y ☐ N

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Y ☐ N ☐ Y ☐ N
   - A. If so, with what company, and what kind of policy?

	Applicant A - Company	Plan
Applicant B – Company		Plan

   - B. What are your start and end dates of coverage under the other policy? (if you are still covered under the other policy, leave "End" blank.)

	Applicant A start date	End date
	/ /	/ /
Applicant B start date	/ /	/ /

4 Health Questions

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed.

If any health questions are answered "yes" in Section 4, the applicant(s) does not qualify for this insurance with us.

Applicant:	A		B	
1. Are you dependent on a wheelchair or any motorized mobility device?	☐ Y	☐ N	☐ Y	☐ N
2. Do any of the following apply to you? Hospitalized two or more times in the last 24 months, currently confined to a bed, in a nursing facility or assisted living facility, receiving home health care or occupational, speech, or physical therapy	☐ Y	☐ N	☐ Y	☐ N
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?				
A. congestive heart failure, unoperated aneurysm, defibrillator	☐ Y	☐ N	☐ Y	☐ N
B. COPD, any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder	☐ Y	☐ N	☐ Y	☐ N
C. leukemia, lymphoma, multiple myeloma, cirrhosis	☐ Y	☐ N	☐ Y	☐ N
D. Parkinson's Disease, Lou Gehrig's Disease (ALS), Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	☐ Y	☐ N	☐ Y	☐ N
E. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	☐ Y	☐ N	☐ Y	☐ N
F. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	☐ Y	☐ N	☐ Y	☐ N
G. hepatitis	☐ Y	☐ N	☐ Y	☐ N
H. myasthenia gravis, systemic lupus or connective tissue disorder	☐ Y	☐ N	☐ Y	☐ N
I. tested positive for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a medical professional as having ARC or AIDS caused by the HIV infection or other sickness or conditions derived from such infection?	☐ Y	☐ N	☐ Y	☐ N
4. Do you have diabetes?				
A. that requires use of insulin greater than or equal to 50 units	☐ Y	☐ N	☐ Y	☐ N
B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage	☐ Y	☐ N	☐ Y	☐ N
C. with history of heart attack or stroke (at any time)	☐ Y	☐ N	☐ Y	☐ N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	☐ Y	☐ N	☐ Y	☐ N
E. that requires 3 or more oral medications to control blood sugar	☐ Y	☐ N	☐ Y	☐ N
5. Within the past 36 months, have you been advised or received drug treatment which requires you to receive the drug through an infusion, IV treatment or injection by a medical professional?	☐ Y	☐ N	☐ Y	☐ N
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?				
A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease	☐ Y	☐ N	☐ Y	☐ N
B. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	☐ Y	☐ N	☐ Y	☐ N
C. any lung or respiratory disorder and use tobacco products	☐ Y	☐ N	☐ Y	☐ N
D. alcoholism, drug abuse	☐ Y	☐ N	☐ Y	☐ N
E. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	☐ Y	☐ N	☐ Y	☐ N
F. internal cancer, melanoma, Hodgkin's Disease	☐ Y	☐ N	☐ Y	☐ N
G. disorder of the pancreas	☐ Y	☐ N	☐ Y	☐ N
H. have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	☐ Y	☐ N	☐ Y	☐ N
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery, including cataract surgery, that has not been performed?	☐ Y	☐ N	☐ Y	☐ N
8. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving treatment?	☐ Y	☐ N	☐ Y	☐ N

4 Health Questions (continued)

Applicant:	A		B	
9. Within the past 12 months, do any of the following apply to you?				
A. had a pacemaker implanted	☐ Y	☐ N	☐ Y	☐ N
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	☐ Y	☐ N	☐ Y	☐ N
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	☐ Y	☐ N	☐ Y	☐ N
D. had a seizure	☐ Y	☐ N	☐ Y	☐ N
10. Within the past 36 months, have you required 3 or more oral medications to control blood pressure?	☐ Y	☐ N	☐ Y	☐ N

5 Applicant A Health History

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason(s) and diagnosis:

2. Within the past 5 years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason(s) and diagnosis:

Use an additional sheet of paper if needed for additional medications or explanation.

3. Prescribed Medications and Dosage	Reason for Medications (diagnosis)

Applicant B Health History

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason(s) and diagnosis:

2. Within the past 5 years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason(s) and diagnosis:

Use an additional sheet of paper if needed for additional medications or explanation.

3. Prescribed Medications and Dosage	Reason for Medications (diagnosis)

6 Applicant A Physician Information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason(s) for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason(s) for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason(s) for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

Applicant B Physician Information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Your primary physician Phone

Physician's office name

City State

Specialist seen in the past 24 months Specialty

Reason(s) for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason(s) for seeing (diagnosis)

Specialist seen in the past 24 months Specialty

Reason(s) for seeing (diagnosis)

Have you seen any additional physicians other than those listed above in the past 24 months? ☐ Yes ☐ No

7 Important Statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this 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. Upon receipt of timely notice, we will either return to you that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at your option, subject to adjustment for paid claims. 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.
5. 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 suspension.
6. 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 Privacy Notice

Although your application is our initial source of information, we may collect information, including health history, prescription drug use and medical records, from persons other than you and we may conduct a telephone interview with you. Montana Health Co-Op, its affiliates, or its reinsurer(s) may also in certain circumstances release information collected by us to third parties without authorization from you, in accordance with federal and state law. Upon written request, we will provide you with the information contained in your file. Medical information will be disclosed to you only through the medical professional you designate. Should you wish to request a correction, amendment or deletion of any information in your file, which you believe inaccurate, please contact us, and we will advise you of the necessary procedures. Upon request, we will provide a detailed privacy notice. The Health Information Authorization which you will submit with this application will be valid for 24 months from the date signed.

9 Agent Compensation

When you purchase insurance from us, we pay compensation to the licensed agent, who represents us for such limited purposes as taking your insurance application, collecting your initial premiums, delivering your policy, and to any intermediaries through which the licensed agent works. This compensation may include commissions when a policy is purchased or renewed, and fees for marketing and administrative services and educational opportunities. The compensation may vary by the type of insurance purchased, or the particular features included with your policy. Additionally, some licensed agents and/or their intermediaries may also receive discounts on their own policy premiums and bonuses, and incentive trips or prizes associated with sales contests based on sales criteria, such as the overall sales volume of an agent or intermediary with our companies, or for the percentage of completed sales. Intermediaries may also pay compensation directly to the licensed agent. If the licensed insurance agent can sell insurance policies from other insurance carriers, those carriers may pay compensation that differs from ours.

10 Applicant(s) Agreement

I hereby apply to Montana Health Co-Op for a policy to be issued in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and acknowledge that to the best of my knowledge and belief, they are true, complete and correctly recorded. I acknowledge that I have received an outline of coverage for the policy applied for and *A Guide to Health Insurance for People with Medicare*.

I understand that I will receive a copy of the signed application, and that a copy is as effective as the original. I acknowledge and agree that if there is more than one applicant on this application, all information provided may be reviewed or shared with the other applicant. I understand that upon acceptance of the completed application, each applicant will receive a separate policy with a copy of this application attached.

I agree (1) this application and any policy, riders, endorsements, and amendments issued will constitute the entire contract of insurance, and the Company will not be bound in any way by any statements, promises or information made or given by or to any agent or other person at any time unless the same is in writing and submitted to the Company at its Medicare Supplement Administrative Office and made a part of such contract. Only a Company Officer can make, modify or discharge contracts or waive any of the Company's rights or requirements and then only in writing; and (2) this application shall not be approved until the first premium is paid, there has been no change in my health as stated in the application, and a policy has been issued by the Company.

I understand and agree that, if I choose to pay my premium by electronic funds transfer (EFT) from my checking or savings account, I authorize Montana Health Co-Op to withdraw my insurance premium from my account and accept the terms and conditions of the EFT authorization attached to this application. This authorization is to remain in effect until I request cancellation. Cancellation may be made by calling 800-366-8354 or writing to the Medicare Supplement Administrative Office address.

I understand that if any answers on this application are incorrect, incomplete or untrue, as to a material fact, Montana Health Co-Op has the right to adjust my premium, reduce my benefits or rescind this policy.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of insurance fraud.

Applicant A signature _____ Date signed _____

X

Applicant B signature _____ Date signed _____

X

12 Agent

All information **must** be completed.

Please list any other medical or health insurance policies sold to **Applicant A**

1. List policies sold which are still in force

2. List policies sold in the past 5 years which are no longer in force

Please list any other medical or health insurance policies sold to **Applicant B**

1. List policies sold which are still in force

2. List policies sold in the past 5 years which are no longer in force

I certify that:

1. I have accurately recorded the information supplied by the applicant(s).
2. The application was provided to the applicant(s) to review and the applicant(s) has been advised that any false statement or misrepresentation in the application may result in an adjustment of premium, reduction of benefits or rescission of the policy(ies).
3. I have provided an outline of coverage for the policy(ies) applied for and *A Guide to Health Insurance for People with Medicare* to applicant(s) prior to completing the application.

The writing number reflects where commissions will be paid.

Agent name *Printed*

Writing number (agent or company)

Agent signature

State license ID number (for FL only)

X

Cell Phone

E-mail

13 Agent Request to Split Commissions

This section must be completed with this application in order to split commissions.

If this application results in an issued policy through Montana Health Co-Op, the agents listed below have agreed to split the commissions earned on the policy.

- Both agents must be properly licensed and appointed with Montana Health Co-Op in the policy's state of issue.
- Split commissions are calculated as a percentage of commissionable premium and will apply while the policy remains inforce.
- The percentage of the premium split can be for any amount but must be stated in whole numbers and total 100%. (For example, the percentage for the premium split can be from 1% to 99% but cannot be 0% or 100%.)
- Calculation of each agent's commissions is based on their respective Montana Health Co-Op commission schedule.

Agent Information *Print*

Writing Agent

Percentage

%

By signing this form, the writing agent agrees to split his/her commission with the secondary agent as indicated above.

Secondary Agent

Writing number

Percentage

%

Writing Agent signature

X

MEDICARE SUPPLEMENT ADMINISTRATIVE OFFICE
P.O. Box 2209
Duncan, OK 73534-2209
Telephone: 800-366-8354

Payment Receipt for Medicare Supplement Insurance

- Type or Print clearly and use blue or black ink.
- Applicant(s) keeps this receipt for their records.
- If only one applicant, just complete **Applicant A** information.

Applicant A name *Printed*

Date of application

/ /

Initial payment collected (if applicable)

☐ Check

$

☐ Money order

EFT draft amount

EFT draft date

$ / /

Applicant B name *Printed*

Date of application

/ /

Initial payment collected (if applicable)

☐ Check

$

☐ Money order

EFT draft amount

EFT draft date

$ / /

This acknowledges receipt of your application for a Montana Health Co-Op Medicare Supplement insurance policy.

Agent name *Printed*

Phone

Signature of agent

X

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to MONTANA HEALTH CO-OP.
- DO NOT make any check payable to the agent and do not leave the payee blank on the check.
- A recorded interview may be required as part of the underwriting on your application for insurance.

Medicare Supplement Insurance - A. If this payment equals the full, initial premium for the mode of premium payment selected by the applicant(s); and B. if the answers are true and correct in the application and if Montana Health Co-Op issues a Medicare Supplement policy according to its rules, limits, and standards for the plan and amount applied for by the applicant(s); then this payment shall be applied to the payment of the first premium of the issued Medicare Supplement policy. No Medicare Supplement policy shall be effective until it has actually been issued by Montana Health Co-Op.

Thank you for choosing Montana Health Co-Op