

## **Mountain 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



**IDAHO**

# 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 including vaping or e-cigarettes in the past 12 months?  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

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 including vaping or e-cigarettes in the past 12 months?  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*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ /\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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

Plan selected:  Plan A  Plan F\*  Plan G  Plan N

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

Requested Medicare Supplement  
effective date: mm/dd/yyyy / /

Payment mode:

Annual  Semi-Annual  Quarterly  Monthly EFT

Modal Premium:

Total Premium:

\$

\$

### Initial Premium:

Draft initial premium upon policy approval

Draft initial premium on policy effective date

### Applicant B

Plan selected:  Plan A  Plan F\*  Plan G  Plan N

Requested Medicare Supplement  
effective date: mm/dd/yyyy / /

Payment mode:

Annual  Semi-Annual  Quarterly  Monthly EFT

Modal Premium:

Total Premium:

\$

\$

### Initial Premium:

Draft initial premium upon policy approval

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 1<sup>st</sup> and 28<sup>th</sup>)

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:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  4<sup>th</sup>

Select the week each month:  1<sup>st</sup>  2<sup>nd</sup>  3<sup>rd</sup>  4<sup>th</sup>

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 Mountain 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 MOUNTAIN 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 Mountain Health Co-Op. The cancelled draft will constitute receipt of premium payment. The privilege of paying premiums under this Plan may be revoked by Mountain 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 Mountain 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

### 3 Eligibility Questions

Please answer all questions.

NOTE: You may be eligible for guaranteed issue of a Medicare Supplement insurance policy, if you have enrolled in Medicare Part B in the last six months and are Medicare eligible if you are age 65 or older, or under age 65 and on Medicare due to a disability or End Stage Renal Disease.

Please refer to "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" for more details on guaranteed issue eligibility.

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?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
A. Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
If yes, what is the effective date?				
<b>Applicant A</b> effective date	____/____/____		<b>Applicant B</b> effective date	____/____/____
B. Are you under age 65 and eligible for Medicare due to a disability?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
C. Are you under age 65 and disabled due to End Stage Renal Disease?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
<hr/>				
2. Are you covered for medical assistance through the state Medicaid program?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
A. If yes: Will Medicaid pay your premiums for this Medicare Supplement policy?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
B. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
<hr/>				
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.				
<b>Applicant A</b> start date	____/____/____		End date	____/____/____
<b>Applicant B</b> start date	____/____/____		End 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?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
B. Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
C. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
<hr/>				
4. Do you have another Medicare Supplement policy in force?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
A. If so, with what company, and what plan do you have?				
<b>Applicant A</b> - Company	_____		Plan	_____
<b>Applicant B</b> - Company	_____		Plan	_____
B. If so, do you intend to replace your current Medicare Supplement policy with this policy?	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
<hr/>				
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	<input type="checkbox"/> Y	<input type="checkbox"/> N	<input type="checkbox"/> Y	<input type="checkbox"/> N
A. If so, with what company, and what kind of policy?				
<b>Applicant A</b> - Company	_____		Plan	_____
<b>Applicant B</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.)				
<b>Applicant A</b> start date	____/____/____		End date	____/____/____
<b>Applicant B</b> start date	____/____/____		End 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
3. Within the past 5 years, have you been medically diagnosed, treated, or had surgery for any of the following?			
A. congestive heart failure, unoperated aneurysm or defibrillator	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. leukemia, lymphoma, multiple myeloma, cirrhosis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's Disease, Lou Gehrig's Disease (ALS), Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. hepatitis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. myasthenia gravis, systemic lupus or connective tissue disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
4. Do you have diabetes?			
A. that has required use of insulin greater than or equal to 50 units within the past 5 years	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. with complications that included retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage within the past 5 years	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. with history of heart attack or stroke within the past 5 years	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. that has required 3 or more oral medications to control blood sugar within the past 5 years	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. any lung or respiratory disorder and use tobacco products	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. alcoholism, drug abuse	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. internal cancer, melanoma, Hodgkin's Disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. disorder of the pancreas	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
H. have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
8. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
D. had a seizure	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	N
10. Within the past 36 months, have you required 3 or more oral medications to control blood pressure	<input type="checkbox"/>	Y	<input type="checkbox"/>	N	<input type="checkbox"/>	Y	<input type="checkbox"/>	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:

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

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

### 3. Prescribed Medications and Dosage

### Reason for Medications (diagnosis)

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

## 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:

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

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

### 3. Prescribed Medications and Dosage

### Reason for Medications (diagnosis)

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<hr/>	<hr/>
<hr/>	<hr/>

## 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. 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.
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 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 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. Mountain 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. 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.

## 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 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 Mountain 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 “*Choosing a Medigap Policy: 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 Mountain 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, Mountain 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

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

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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 "Choosing a Medigap Policy: 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 Mountain 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 Mountain 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 in force.
- 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 Mountain Health Co-Op commission schedule.

### Agent Information *Print*

Writing Agent

Percentage

---

%

Secondary Agent

Writing number

Percentage

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%

Writing Agent signature

**X**

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



**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.

<b>Applicant A name</b> <i>Printed</i>	Date of application
_____	____/____/____
Initial payment collected (if applicable)	<input type="checkbox"/> Check
\$ _____	<input type="checkbox"/> Money order
EFT draft amount	EFT draft date
\$ _____	____/____/____

<b>Applicant B name</b> <i>Printed</i>	Date of application
_____	____/____/____
Initial payment collected (if applicable)	<input type="checkbox"/> Check
\$ _____	<input type="checkbox"/> Money order
EFT draft amount	EFT draft date
\$ _____	____/____/____

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

Agent name <i>Printed</i>	Phone
_____	_____
Signature of agent	
_____	

**X**

- Payment will be refunded for any coverage not issued.
- All premium payments must be made payable to Mountain 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 Mountain 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 Mountain Health Co-Op.

**Thank you for choosing Mountain Health Co-Op**