2022 Application

Alliance Medicare Supplement Plan

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

All sections must be completed unless otherwise indicated.

1 Tell us about yourself

First, Middle Initial and Last Name _____ /_____/_____

Gender ◯M ◯F Birth Date ____/____/_____ (M M D D Y Y Y Y) Social Security Number _____-_____-_____

Phone Number (_____) _____ - _____ Email Address _____

Address _____

City _____ State _____ Zip _____

Please refer to your Medicare Health Insurance card for the following information:

Medicare Number: _____

Part A and Part B Effective date ____/01/_____ (M M D D Y Y Y Y) ____/01/_____ (M M D D Y Y Y Y)

2 Select the Alliance Medicare Supplement Plan that best meets your needs

Your plan choices are based on your age and other factors, like current Medicare enrollment. You must be a permanent resident of Michigan to purchase an Alliance Medicare Supplement insurance policy. Please refer to the enclosed *Outline of Coverage* for the monthly cost of the plan and description of what each plan covers.

Your coverage will become effective on the **first day of the month** following receipt and approval of your completed enrollment application. You may also request a later coverage date. Please indicate your choice:

Requested coverage date: ____/01/_____ (M M D D Y Y Y Y) This month will be your first month of coverage.

AGING IN TO MEDICARE*:

If you turn 65 and become eligible for Medicare on or after 1/1/2020, you are eligible for these plans:
◯Plan A ◯Plan D ◯Plan G ◯Plan N

If you are younger than 65, and become eligible for Medicare on or after 1/1/2020, you are eligible for these plans: ◯Plan A ◯Plan G

ALREADY ENROLLED IN MEDICARE*:

If you will be 65 or older in your first month of coverage and your first month of coverage began prior to 1/1/2020, you are eligible for these plans:
◯Plan A ◯Plan C ◯Plan D ◯Plan F ◯Plan G ◯Plan N

If you are younger than 65, are eligible for Medicare, and your first month of coverage began prior to 1/1/2020, you are eligible for these plans:
◯Plan A ◯Plan C

** You must be enrolled in Medicare Parts A and B, and must not have more than one Medicare supplement policy to be eligible for any plan.*

3 Optional Dental and Vision Packages*

Please select the optional package to buy:

◯ PACKAGE 1 - $27.36 additional monthly premium plan
◯ PACKAGE 2 - $48.42 additional monthly premium plan
◯ PACKAGE 3 - $51.78 additional monthly premium plan
◯ OPT OUT of dental and vision coverage

**Network restrictions apply. See enclosed flyer or Outline of Coverage for details.*

Questions? Call (833) 923-1797 (TTY: 711) and talk to a HAP Medicare sales representative.

4 You may qualify for guaranteed acceptance

	YES	NO
1. Did you turn 65 within the last six months or will you turn 65 within your first month of requested coverage? ..... If YES, your acceptance is guaranteed. **SKIP TO SECTION 6.**	◯	◯
2. Did you enroll in Medicare Part B **for the first time** within the last six months? ..... If YES, your acceptance is guaranteed. **SKIP TO SECTION 6.**	◯	◯
3. Have you lost or are you losing other credible health insurance coverage and received a notice from your prior insurer? ..... If YES, you **may be** guaranteed acceptance in plan C, D, F or G. You must provide your loss of coverage notice from your previous employer. Please email to: HAPMedicareAgent@hap.org. **SKIP TO SECTION 6.**	◯	◯
4. Are you currently covered under the Medicare Advantage plan or PACE program you joined at 65 when you were first eligible for Medicare Part A and are applying for this coverage within your 12-month trial right period? ..... If YES, you **may be** guaranteed acceptance in plan C, D, or F. **SKIP TO SECTION 6.**	◯	◯

5 Complete this section (Do not complete this section if you qualify for guaranteed acceptance.)

The information you provide is confidential and will be used and disclosed only as permitted by our Notice of Privacy Practices, which you can read online at www.hap.org/privacy

HEALTH INFORMATION

	YES	NO
(a) In the past two years, I have used tobacco in any form	◯	◯
(b) Are you enrolled in Medicare before age 65 due to disability? ..... If YES, please explain the type of disability and how long you have been covered by Medicare. _____	◯	◯
(c) Please select Yes or No for:		
(1) I have been diagnosed with End Stage Renal (kidney) Disease (ESRD)	◯	◯
(2) I have kidney disease that will require dialysis	◯	◯
(3) I currently receive dialysis	◯	◯
(4) I have been hospitalized overnight in the last 90 days	◯	◯

If "yes", why were you hospitalized, for what condition(s)? _____

(d) Height: _____feet _____inches Weight: _____pounds

(e) Have you, due to mental or physical disability, authorized any person or institution to legally act on your behalf and take over your personal business transactions, and if "yes", is that person currently acting on your behalf under a legal Power of Attorney?. ..... If YES, please provide their name and relationship and include a copy of the Financial Power of Attorney, Letter of Conservatorship or other legal documents with this application	◯	◯

Name: _____Relationship: _____

(f) In the past 12 months, have you been told you will need treatment, tests or surgery that has not yet been done?	◯	◯

If YES, please explain: _____

Questions? Call (833) 923-1797 (TTY: 711) and talk to a HAP Medicare sales representative.

5 HEALTH INFORMATION (continued) **YES** **NO**

(g) In the past 12 months, have you been hospitalized? ..... ◯ ◯

If YES, please explain the date(s) and reason(s) for each hospital stay, and the length of each hospital stay: _____

(h) Do you visit any medical doctors or providers more than monthly for medical advice or treatment? ..... ◯ ◯

If YES, please explain: _____

(i) In the past 2 years, have you been diagnosed with, treated, or been advised to be treated for any of the following:

(1) Cancer (except basal cell skin cancer) ❑ leukemia ❑ lymphoma ❑ melanoma ❑ or other cancer ❑

(2) Chronic Lung Disease ❑ COPD ❑ emphysema ❑ mesothelioma ❑ cystic or pulmonary fibrosis or any other respiratory disorder ❑

(3) Cirrhosis of the liver ❑ any liver or pancreas disease ❑ hepatitis C ❑ kidney disease ❑

(4) Diabetes ❑
Please check all of the following treatments or conditions which also apply:
Insulin use ❑ insulin pump ❑ neuropathy ❑ hypertension ❑ kidney problems ❑ amputation ❑ retinal/eye issues ❑

(5) Stroke ❑ TIA (transient ischemic attack) ❑ hemophilia ❑ or clotting disorder ❑

(6) Angina pectoris ❑ heart attack ❑ congestive heart failure ❑ valvular heart disease ❑ any heart disease ❑ atrial fibrillation ❑ have a pacemaker ❑ carotid artery disease ❑ cardiomyopathy ❑ pulmonary hypertension ❑ left bundle branch block ❑ or other heart conditions ❑

(7) Alzheimer's Disease ❑ Parkinson's Disease ❑ ALS (Lou Gehrig's Disease) ❑ Cerebral Palsy ❑ Muscular Dystrophy ❑ Huntington's Disease ❑ Multiple Sclerosis (MS) ❑ paralysis ❑ quadraplegia ❑ hemiplegia ❑ or other neurological disorder ❑

(8) Any immune system disorder ❑ AIDS ❑ HIV+ ❑ lupus ❑ rheumatoid arthritis ❑ Crohn's Disease ❑

(9) Any psychological disorder such as schizophrenia ❑ bipolar disorder ❑ major depression ❑ suicide attempt ❑ substance abuse ❑ or other mental condition requiring outpatient or inpatient treatment ❑

(10) Any organ ❑ or bone marrow transplant ❑

(11) Any systemic lupus ❑ joint replacement ❑ or back or spine surgery?

If YES, please explain: _____

_____

(j) Are you taking prescription medications? ..... ◯ ◯

If YES, please list medications and the conditions for which they are taken:

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

5 HEALTH INFORMATION (continued)

(k) When was your last doctor visit and your last physical?

Date: _____Reason for visit: _____

Tests performed: _____

Test results or recommendations: _____

(l) Do you have any other medical conditions not previously mentioned? ..... YES ◯ NO ◯

Please provide details for all "yes" answers. Include diagnosis, treatments, dates and current status.

Question #	Condition/Diagnosis	Treatment	Dates	Current Status

Authorization for the Release of Medical Information

I understand that Alliance Health and Life Insurance Company (Alliance) may need to collect personal information about me from outside sources in order to approve my Alliance Medicare Supplement Application.

I authorize Alliance to review and look at its own records for information needed to process this application.

I authorize any medical professional, doctor, hospital, clinic or other medical facility, government agency or other medical person to disclose information, including copies of records concerning advice, care or treatment provided to me in order for Alliance to review and evaluate this application. This authorization does not permit the disclosure of provider's notes from psychotherapy sessions that are separate from the provider's other medical records.

For purposes of determining my qualification for coverage, this authorization is valid for 24 months from the date of my signature.

I understand that signing this authorization is voluntary. I can refuse to sign this authorization. But if I don't sign the authorization I may not be eligible to enroll in coverage with Alliance.

I understand that my information may be shared with others as part of this authorization and that when the information is shared it may no longer be protected by federal privacy laws.

I can revoke this authorization at any time by sending written notice to:
HAP Customer Service; 1414 E. Maple Road, Troy, MI 48083. I understand that revocation will not affect any action taken in reliance on this authorization before Alliance gets my notice to revoke.

If you are signing as the authorized personal representative you must provide this information and enclose or attach a copy of the appropriate legal documentation.

5 HEALTH INFORMATION (continued)

Applicant Signature

✗ _____

YOUR SIGNATURE (REQUIRED) DATE (REQUIRED) ____ / ____ / 20____
M M D D Y Y Y Y

PERSONAL REPRESENTATIVE NAME
(if legal Power of Attorney is enacted) _____

✗ _____

PERSONAL REPRESENTATIVE SIGNATURE (REQUIRED) DATE (REQUIRED) ____ / ____ / 20____
M M D D Y Y Y Y

ADDRESS _____

PHONE (_____) _____ - _____ RELATIONSHIP TO APPLICANT _____

6 For your protection, you are required to read the statements below and answer all the questions.

Please read these statements

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If you are eligible for Medicaid at any age, you may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy may be suspended during your entitlement to benefits under Medicaid for 24 months at your request. 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 reinstituted if requested within 90 days of losing Medicaid eligibility.
- 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.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.
- 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 have guaranteed issue rights in one or more of our Medicare supplement plans.

6 Read and Answer all Questions (continued)

Please answer all these questions to the best of your knowledge. Clearly mark the correct answer.

	YES	NO
(1) Are you covered for medical assistance through the state Medicaid program? (Note: 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 supplement policy?	◯	◯
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	◯	◯
(2) (a) Do you have an active Medicare supplement policy?	◯	◯
If YES, with what company, and what plan do you have?		
(b) If YES, do you intend to replace your current Medicare supplement policy with this policy?	◯	◯

_____

(3) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ◯ ◯

(a) If YES, with what company and what kind of policy?

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

START (MM DD YYYY) ____/____/_____ END (MM DD YYYY) ____/____/_____

(If you are still covered under this policy, leave "END" blank.)

_____

7 This section is very important. Your application will not be processed unless you sign and date below.

- My signature below indicates that I have read and understand the contents of this application.
- I acknowledge receipt of the Alliance Medicare Supplement *Outline of Coverage* and *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
- I declare that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, Alliance Health and Life Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- 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, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand that the coverage under the plan I am applying for will not take effect until issued by Alliance Health and Life Insurance Company.
- Prior to canceling any other coverage, please make sure policy has been approved.
- You will receive a Medigap Policy Booklet confirming your coverage date. We will accept an application 90 days in advance of the effective date.

If you find that you are not satisfied with your policy, send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

If you are signing as the authorized personal representative you must provide this information and enclose or attach a copy of the appropriate legal documentation.

Questions? Call (833) 923-1797 (TTY: 711) and talk to a HAP Medicare sales representative.

7 STATEMENTS (continued)

Applicant Signature

✗ _____

YOUR SIGNATURE (REQUIRED) DATE (REQUIRED) ____ / ____ / 20____
M M D D Y Y Y Y

PERSONAL REPRESENTATIVE NAME
(if legal Power of Attorney is enacted) _____

✗ _____

PERSONAL REPRESENTATIVE SIGNATURE (REQUIRED) DATE (REQUIRED) ____ / ____ / 20____
M M D D Y Y Y Y

ADDRESS _____

PHONE (_____) _____ - _____ RELATIONSHIP TO APPLICANT _____

* If you have authorized any person or institution to legally act on your behalf and take over your personal business transactions, please provide their name and relationship and include a copy of the Financial Power of Attorney, Letter of Conservatorship or other legal documents with this application.

8 Household Discount

	YES	NO
Is an existing member of your household also applying for a HAP Medicare Supplement Plan?	◯	◯
Does an existing member of your household have an active HAP Medicare Supplement Plan?	◯	◯

If YES to one or both questions, please list member name and HAP subscriber ID#.

HAP Medicare Supplement Member Name: _____

HAP ID# _____

Household members may be eligible for a discount when they both are enrolled in a HAP Medicare Supplement Plan.

9 Paying your plan premium

Please select a premium payment option. If you don't select a payment option, you will receive a bill each month.

◯ Receive a bill and pay by mail

◯ Electronic funds transfer (EFT) from your bank account each month.

This service is free and can take 30 to 60 days to start. Premiums already billed will not be deducted automatically. Please continue to pay your premium as you normally would until your monthly invoice states the premium payment will be automatically withdrawn.

Account Holder Name: _____

Bank Routing Number _____

Bank Account Number _____

Account Type: ◯ Checking ◯ Savings

Questions? Call (833) 923-1797 (TTY: 711) and talk to a HAP Medicare sales representative.

9 PAYING YOUR PREMIUM (continued)

Failure to pay the total premium on either medical or dental/vision package will result in termination of the entire policy. You must pay your plan premiums to continue being a member of our plan.

How to submit this application*

Online at **http://www.hap.org/medicare**

Email to: **hapmedicareagent@hap.org**

Applicants may also mail in applications at:

Health Alliance Plan
Attention: Medicare Sales
1414 E. Maple Road
Troy, MI 48083

*Agents must submit applications online at **http://www.hap.org/medicare** or email to **hapmedicareagent@hap.org**

10 For agent/broker use only

AGENT NAME (REQUIRED)	NATIONAL PRODUCER NUMBER (REQUIRED)
✗ AGENT/NATIONAL PRODUCER SIGNATURE (REQUIRED)	DATE (REQUIRED) ____ /____/ 20____ MM DD YYYY

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

Alliance Health and Life Insurance Company is a wholly-owned subsidiary of Health Alliance Plan