Application

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

Alliance Medicare Supplement Plan

All sections must be completed unless otherwise indicated.

1 Tell us about yourself

First and Last Name ____________________

Address ____________________

City ____________________ State ____ Zip ____________

_______ - _____ - _______
Social Security Number

Birth Date _____ / _____ / _________
M M / D D / Y Y Y Y

Gender ○ M ○ F

(_______) _______ - __________
Phone Number

Email Address (optional) ____________________

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

Medicare Number: ____________________

Medicare Part A coverage start date _____ / 0 1 / _________
M M / D D / Y Y Y Y

Medicare Part B coverage start date _____ / 0 1 / _________
M M / D D / Y Y Y Y

If you are working with an Agent, please provide the Agent's name and phone number.

Agent Name ____________________

(_______) _______ - __________
Agent Phone Number

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 and actually live in Michigan for at least six months of every year 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. We must receive your application at least 30 days prior to your requested coverage effective date (coverage date). You will receive a Certificate of Insurance confirming your coverage date.

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: _____ / 0 1 / _________ . This month will be your first month of coverage.
M M / D D / Y Y Y Y

If you turn 65 or will be older than 65 in your first month of coverage and are enrolled in Medicare Parts A and B, and you do not have more than one Medicare supplement policy.

Choose one of these plans: ❍ Plan A ❍ Plan C ❍ Plan F ❍ Plan G ❍ Plan N

If you are younger than 65 in your first month of coverage and are enrolled in Medicare Parts A and B, and you do not have more than one Medicare supplement policy.

Choose one of these plans: ❍ Plan A ❍ Plan C (You are not eligible for Plan F, Plan G, or Plan N.)

Questions? Call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

3 You may qualify for guaranteed issue rights

	YES	NO
1. Did you turn 65 within the last six months or will you turn age 65 within your first month of requested coverage?	❍	❍

If YES, your acceptance is guaranteed. **SKIP TO SECTION 5.**

	YES	NO
2. Did you enroll in Medicare Part B **for the first time** within the last six months?	❍	❍

If YES, your acceptance is guaranteed. Please include your Medicare Part B coverage start date then **SKIP TO SECTION 5.**

Medicare Part B coverage start date: ______ / 0 1 / __________
MM DD YYYY

	YES	NO
3. Have you lost or are you 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 a Medicare supplement insurance policy?	❍	❍

If YES, 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 and **SKIP TO SECTION 5.**

	YES	NO
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 one or more of our Medicare supplement plans and **SKIP TO SECTION 5.**

4 Complete this section

(Do not complete this section if your answers above indicate you can skip to section 5.)

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) 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.

____

(b) Please select Yes or No for:

	YES	NO
(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	❍	❍
(c) In the past two years, I have used tobacco in any form	❍	❍

(d) Height: _______feet _______inches Weight: ______pounds

	YES	NO
(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?	❍	❍

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.

____

Questions? Call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

4 HEALTH INFORMATION (continued)

	YES	NO
(f) In the past 12 months, have you been told you will need surgery but it has not yet been done?	❍	❍

If YES, please explain: ______________________________

____

	YES	NO
(g) In the past 12 months, have you been hospitalized as an inpatient?	❍	❍

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

	YES	NO
(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 or treated or have you been advised to be treated for:

	YES	NO
(1) Cancer (except basal cell skin cancer) or leukemia	❍	❍
(2) Chronic Lung Disease, or COPD, or emphysema	❍	❍
(3) Cirrhosis of the liver, or any liver or pancreas disease	❍	❍
(4) Diabetes (insulin dependent), or neuropathy, or kidney disorder, or retinopathy or amputation	❍	❍
(5) Stroke or clotting disorder	❍	❍
(6) Angina Pectoris, or Heart Attack, or Congestive Heart Failure, or Valvular Heart Disease, or any Heart Disease, or atrial fibrillation, or have a pacemaker, or carotid artery disease	❍	❍
(7) Alzheimer's Disease	❍	❍
(8) Parkinson's Disease or ALS (Lou Gehrig's Disease)	❍	❍
(9) Multiple Sclerosis, or quadriplegia, or hemiplegia or paralysis	❍	❍
(10) Organ or bone marrow transplant	❍	❍
(11) Systemic lupus, or joint replacement or back or spine surgery	❍	❍

	YES	NO
(j) Are you taking prescription medications?	❍	❍

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

Medication: ____________________ Reason for use: ____________________

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Medication: ____________________ Reason for use: ____________________

Medication: ____________________ Reason for use: ____________________

(If you need to list more medications, please attach a sheet of paper to your application. Please print and sign your full name, and include the date on the paper.)

(k) When was your last doctor visit?

Date: __________ Reason for visit: ____________________

Tests performed: ______________________________

Test results or recommendations: ______________________________

Questions? Call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

4 HEALTH INFORMATION (continued)

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

If YES, please provide details, treatment, dates, and current status. Do not share family medical history or your genetic test information. ___________________________________

____

(If you need to list more information, please attach a sheet of paper to your application. Please print and sign your full name, and include the date on the paper.)

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; 2850 W. Grand Blvd Detroit, MI 48202. I understand that revocation will not affect any action taken in reliance on this authorization before Alliance gets my notice to revoke.

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

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.

PERSONAL REPRESENTATIVE NAME ____

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

ADDRESS ____

PHONE (______) ______ - __________ RELATIONSHIP TO APPLICANT ______________________

Questions? Call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

5 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.

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) 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.		

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

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

	YES	NO
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	❍	❍
(b) Was this your first time in this type of Medicare plan?	❍	❍
(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan?	❍	❍

Questions? Call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

5 STATEMENTS (continued)

	YES	NO
(3) (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?	❍	❍
(4) 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.)

6 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.

✗ ______________________

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

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.

PERSONAL REPRESENTATIVE NAME ______________________

✗ ______________________

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

ADDRESS ______________________

PHONE (_____) _____ - _______ RELATIONSHIP TO APPLICANT ______________________

Questions? Call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

How to submit this application*

Online at www.hap.org/medicare

Fax to: (313) 664-5431

Mail to:
Health Alliance Plan
Attention: Medicare Sales
21700 Northwestern Hwy
Southfield, MI 48075-9841

*Agents must submit applications online at www.hap.org/medicare or by Fax.

If you have questions or need help completing this application, call (800) 868-3153 (TTY: 711) and talk to a HAP Medicare sales representative.

8 a.m. to 8 p.m. ET, seven days a week (Oct. 1 - March 31)
8 a.m. to 6 p.m. ET, Monday through Friday (April 1 - Sept. 30)

Remember:

- 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.
- If applicable, please include a copy of the notice from your prior insurer with your application.
- We must receive your application at least 30 days prior to your requested coverage date.

For agent use only

AGENT NAME (REQUIRED) ______________________

NATIONAL PRODUCER NUMBER (REQUIRED) ______________________

✗ ______________________
AGENT/NATIONAL PRODUCER SIGNATURE (REQUIRED)

DATE (REQUIRED) ____ / ____ / 20 ____ (MM / DD / YYYY)

If you are working with a licensed insurance agent, the agent will fill out this section for you.

If this policy is sold by a sales agent, the agent shall list other health coverage sold to the applicant.

Policies still in force ______________________

____

Policies no longer in force and sold in the last five years ______________________

____

Revised 10/18

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

2850 W. Grand Blvd., Detroit, MI 48202

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MED SUPP ENR APP 0818 - APPROVED

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

Notice to applicant regarding replacement of existing Medicare Supplement or Medicare Advantage coverage.

(Notice is completed by insurer, agent or other representative.)

Alliance Health and Life Insurance Company
2850 W. Grand Blvd.
Detroit, Michigan 48202

Save this notice! It contains important information you may need in the future.

According to your Alliance Medicare Supplement application, you plan to drop or otherwise terminate your existing Medicare supplement or Medicare Advantage plan and replace it with a policy or certificate from Alliance Health and Life Insurance Company®. Your new policy or certificate gives you 30 days to decide if you want to keep the policy or certificate. During the 30 days, you will not be charged.

Please take the time to carefully review your new Alliance Medicare Supplement policy before you terminate your existing coverage. Compare it with all disability and other health coverage you now have. You should carefully consider if terminating your existing coverage for this new Medicare supplement policy is the best decision for you.

Statement to applicant by insurer, agent or other representative:

I have reviewed your existing medical or health coverage. The replacement of coverage involved in this transaction does not duplicate your existing Medicare supplement policy – or your Medicare Advantage coverage, if applicable. This is true because you intend to terminate your existing Medicare supplement policy or leave your Medicare Advantage plan, to the best of my knowledge. The replacement policy is being purchased for the following reason (check one):

____ Additional benefits

____ No change in benefits, but a lower premium

____ Fewer benefits and a lower premium

____ Existing plan has outpatient prescription drug coverage, and you are enrolling in a Medicare Part D plan

____ Disenrollment from a Medicare Advantage plan. Please explain the reason for disenrollment:

____

____ Other reason (please specify): ____

1. Health conditions you 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, although a similar claim might have been payable under your existing policy.

2. Your insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy or certificate for similar benefits if the period had elapsed under the original coverage.

3. If, after thinking about it carefully, you still wish to drop your existing coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history.

   If you fail to include all related medical information on the application, it could result in the non-payment of future claims, and your policy may be cancelled and premiums refunded as though your policy or certificate had never been in effect.

   Before you sign your application, read it over carefully. You should confirm that all the information being submitted is complete and correct.

4. Do not cancel your existing policy until you have received your new policy and are sure that you want to keep it.

____

Signature of agent, broker or other representative

____

Printed name and address of agent, broker or other representative

____

(Date)

The above notice was delivered to me on:

____

(Date)

____

(Applicant's signature)

____

(Applicant's printed name)

____

(Applicant's address)

____

(Policy, certificate or contract number being replaced)

Revised 10/18

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