



100 Lillian Gish Blvd.  
 P.O. Box 4816  
 Massillon, OH 44648-4816  
 Phone: 330.834.2200 • 1.877.236.2289

**MEDICARE SELECT ENROLLMENT  
 APPLICATION - OHIO**

**INSTRUCTIONS**

To be considered complete, all sections on this form must be filled out, unless marked optional. Please sign and date the form and make a copy for your records. **Incomplete forms could delay processing your enrollment.** For information call 1-877-236-2290; TTY/TDD (Hearing Impaired) 1-877-236-2291.

**TO BE COMPLETED BY THP**

GROUP # \_\_\_\_\_ DIVISION # \_\_\_\_\_  
 CHECK # \_\_\_\_\_ AMOUNT \_\_\_\_\_

**APPLICANT INFORMATION**

LAST NAME	FIRST NAME	MI	SEX
HOME ADDRESS	STREET	CITY	STATE
	ZIP	COUNTY	
BILLING ADDRESS (IF DIFFERENT FROM HOME ADDRESS)			
PHONE NUMBER	BIRTHDATE MONTH/DAY/YEAR	SOCIAL SECURITY NUMBER	

**FOR WHICH PLAN ARE YOU APPLYING?**

*(Check one. Refer to the sales materials for descriptions of plans.)*

- PLAN A     PLAN C     PLAN D     PLAN F

Requested effective date of coverage \_\_\_\_\_

New enrollment \_\_\_\_\_

Change to enrollment \_\_\_\_\_

MEDICARE	HEALTH INSURANCE										
SOCIAL SECURITY ACT											
Medicare Claim Number (please include letter)											
<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> </table>											
Hospital Insurance (Part A)											
effective date:	MONTH/DAY/YEAR										
Medical Insurance (Part B)											
effective date:	MONTH/DAY/YEAR										

**THE FOLLOWING INFORMATION IS REQUIRED BY FEDERAL REGULATIONS**

Please be aware that:

- 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 whether you need multiple coverages.
  - You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
1. 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 and premiums under your Medicaid for 24 months. You must request suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement or, if the Medicare Supplement policy 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 are 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.

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.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**2. MEDICAL AND GENERAL**

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. PLEASE ANSWER ALL QUESTIONS.

Please Mark **Yes** or **No** with an "X"

**To the best of your knowledge,**

- (1) Did you turn age 65 in the last 6-months? Yes No
  - (a) Did you enroll in Medicare Part B in the last 6-months?..... Yes No
  - (b) **IF YES**, what is the effective date? \_\_\_\_\_
  - (c) If you are under age 65, have you been diagnosed with or treated for End-Stage Renal Disease (ESRD)?..... Yes No
- (2) Are you covered for medical assistance through the state Medicaid program?..... Yes No  
**(NOTE TO APPLICANT:** Please answer **NO** to this question if you are participating in a "Spend-Down Program" and have not met your "Share of Cost.")  
**IF YES,**
  - (a) Will Medicaid pay your premiums for this Medicare supplement policy?..... Yes No
  - (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium?..... Yes No
- (3) If you had coverage from any Medicare plan other than the original Medicare plan within the last 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.  
 START \_\_\_/\_\_\_/\_\_\_      END \_\_\_/\_\_\_/\_\_\_

- (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?..... Yes No
- (b) Was this your first time in this type of Medicare plan?..... Yes No
- (c) Did you drop a Medicare supplement policy to enroll in this Medicare plan?..... Yes No
- (4) Do you have another Medicare supplement policy in force?..... Yes No  
**IF YES,**
  - (a) With what company and what plan do you have?  
 \_\_\_\_\_
  - (b) Do you intend to replace your current Medicare supplement policy with this policy?..... Yes No
- (5) Have you had coverage under any other health insurance plan within the past 63 days? (for example employer, union or individual plan)..... Yes No  
**IF YES,**
  - (a) With what company and what kind of policy? \_\_\_\_\_
  - (b) What are your dates of coverage under the policy? (If you are still covered under the other policy, leave "END" blank).  
 START \_\_\_/\_\_\_/\_\_\_      END \_\_\_/\_\_\_/\_\_\_

**Health History and medical Provider Information (If this section applies to you, answer all questions.)**

**READ CAREFULLY - This section may not apply to you.** Please "✓" the box if any of the following apply to you:

- Your coverage will start **3 months before or after your 65<sup>th</sup> birthday;**
- Your coverage will start when you are age **65 or older and within 6 months of your Medicare Part B** coverage effective date; **OR**
- You qualify for guaranteed-issue coverage for another reason

If you checked any of the above, please **skip** this section.

- 1. In the past ten years have you been treated for or had any indication of:
  - a. cancer, leukemia, Hodgkin's disease, tumor, or cyst;..... Yes No
  - b. arthritis, osteoporosis, or other disorder of the bones, joints, spine or muscles;..... Yes No
  - c. diabetes, thyroid or other glandular disorder;..... Yes No
  - d. alcoholism or drug use or addiction..... Yes No
  - e. Alzheimer's, Parkinson's, fainting attacks or other mental/nervous disorders;..... Yes No
  - f. heart trouble, stroke, high blood pressure, chest pains, anemia or other disorder of the blood vessels;..... Yes No
  - g. asthma, emphysema or other disorder of the lungs;..... Yes No
  - h. ulcer or other disorder of the stomach, intestines, liver or gall bladder;..... Yes No
  - i. hernia, overweight or underweight condition..... Yes No
  - j. kidney trouble, kidney stones, or other disorder of the urinary bladder, prostate or genitourinary tract;.... Yes No
  - k. any disease or disorder of the central nervous system Yes No

- 2. In the past five years have you:
  - a. been examined, treated by, or consulted a physician, chiropractor or other medical practitioner for any reason, including routine examination; or been under observation or treatment in any clinic, hospital, sanitarium or similar institution? Yes No
  - b. had any illness, injury, operation or impairment which has not already been mentioned?
- 3. Are you presently taking any medication? Yes No  
 If so, please name \_\_\_\_\_
- 4. Have you had any difficulty obtaining life or health insurance due to health problems? Yes No
- 5. Have you, in the past five years, used any form of tobacco or related substances? Yes No
- 6. Height \_\_\_\_\_
- 7. Weight \_\_\_\_\_
- 8. State of birth \_\_\_\_\_
- 9. State of residence \_\_\_\_\_

If you answered "yes" to any part of 1, 2, 3, or 4 above, then it is necessary for you to have the attending physician provide further details by completing the attached Physician's Statement.



**RELEASE AUTHORIZATION - PLEASE READ CAREFULLY BEFORE SIGNING**

Please sign and date where indicated on this page. PLEASE MAKE A COPY FOR YOUR RECORDS.

IT IS IMPORTANT THAT YOU READ AND UNDERSTAND THE FOLLOWING BEFORE YOU SIGN. By filing this application and applying for this coverage, I agree to or with the following:

1. THP may decline this Application. No coverage comes into effect until THP approves this Application.
2. Coverage and benefits, once they come into effect, are contingent on a timely and accurate payment of premiums and any other contribution provided in the plan documents. If premium payments are not paid on time and accurately, your coverage will be terminated. If you are terminated for nonpayment of premium, you may no longer be eligible to enroll in THP's Medicare Select Supplement plan.
3. I authorize THP to request my medical records, any prescribed medication history and any other medical or pharmaceutical information to process my Application and to make a decision on the approval or disapproval of my Application. I authorize any physician, other healthcare professionals, hospital, clinics, labs, pharmacies, pharmacy benefit managers or any other healthcare organization ("Providers") that provided treatment of any other service to me to disclose the information required by THP and described above to THP and/or its designated agents. This authorization will be valid for thirty (30) months from the date this application is signed. I understand that I may revoke this authorization at any time while THP is determining eligibility for the coverage requested. To do so, I must notify THP in writing prior to the issuance of the policy. Revocation of this authorization will result in the closure of my Application.
4. I understand that THP will rely on such information to: 1) underwrite this Application for coverage, make eligibility, risk rating, policy issuance and enrollment determination; 2) administer claims and determine or fulfill responsibility for coverage and provisions of benefits; 3) administer coverage; and 4) conduct other insurance operations according to federal and state laws and regulations. I authorize THP to use such information and to disclose such information to affiliates. Providers, payers, and other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. This authorization will remain valid for the term of the coverage and so long thereafter as allowed by law. I understand that THP will comply with HIPPA Privacy Rules and that disclosures of such information will be done in accordance with applicable law.
5. I understand that I am entitled to receive a copy of this Application upon request, and that a photocopy is as valid as the original.
6. Providers are independent contractors and are not agents of THP.
7. Information on insurance agent/broker compensation is available from your agent or at [www.healthplan.org](http://www.healthplan.org).
8. I have an obligation of communicating to THP in writing any medical conditions which occur to Applicant listed in this Application after the Application date and before the effective date of coverage, if approved.
9. Misrepresentation - I understand that any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I UNDERSTAND THAT IF MY SIGNATURE/DATE DO NOT APPEAR AND/OR ARE NOT CURRENT AND/OR MY ANSWERS ARE INCOMPLETE, my application will be declined.

I acknowledge receipt of a copy of "A Guide to Health Insurance for People with Medicare" and an Outline of Coverage, and that I have made a copy of this Application.

Applicant's Signature: \_\_\_\_\_ Application Date: \_\_\_\_\_

Power or Attorney or Legal Guardian Signature\*: \_\_\_\_\_

\*If Applicant is unable to sign, a court-appointed legal guardian or a designee authorized by state law must sign above.

Attach a copy of the document that designates this person as the Applicant's representative.

**PRODUCER CERTIFICATION - This Section To Be Completed By THP Sales Representative Only**

The undersigned Agent certifies that the Applicant has read, or had read to him/her, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

List all health insurance policies (including Medicare Supplement policies) you have sold to the applicant which are still in force. (attach separate sheet, if necessary)

Company: \_\_\_\_\_ Type: \_\_\_\_\_

List all health insurance policies sold to the applicant within the past 5 years which are no longer in force.

Company: \_\_\_\_\_ Type: \_\_\_\_\_

I certify: 1) I have accurately recorded the information supplied by the Applicant; and (2) I have given an Outline of Coverage for the policy applied for and I reviewed the current health insurance coverage of the applicant and find additional coverage of the type and amount for the Applicant's needs is:  Appropriate  Inappropriate

Signature of Producer: \_\_\_\_\_