



Important Notice: Refer to the Guaranteed Issue Guide to determine eligibility for automatic acceptance. If eligible, indicate which situation is applicable in the Guaranteed Issue section. If you qualify for automatic acceptance, you are not required to complete the Statement of Health section.

Read Important Notice above before completing this application.



Eligibility:

To be eligible for a Medicare Supplement insurance policy, you must be:

- Enrolled under federal Medicare Hospital Insurance (Part A) and federal Medicare Medical Insurance (Part B) at the time you apply.
- A resident of Ohio or West Virginia.
- Age 65 or older.
- Only applicant's first eligible for Medicare before January 1, 2020 may purchase Plans C, F, and high deductible F.

Instructions:

Provide **all** requested information.

Type or print clearly in ink.

Sign and date all places indicated.

Submit the application within 30 days of the applicant's signature date. Submit one month's premium with the application in the form of a check made payable to The Health Plan, or a completed ACH form to have premiums drafted from your checking or savings account.

Use the enclosed postage-paid return envelope to mail in the application to The Health Plan, 1110 Main Street, Wheeling, WV 26003.

If you need assistance completing your application, please call 1.877.847.7915; (TTY: 711).



Ohio and West Virginia Application

THP Medicare Supplement Insurance Coverage

CHECK ONE

I am applying for: New Coverage Change to My Current Coverage; ID# _____

Section I – Applicant Information

Social Security Number: _____ Date of Birth: _____ Gender: M F

First Name: _____ Middle Initial: _____ Last Name: _____

Residential Address: _____ County: _____

City: _____ State : _____ ZIP: _____

Telephone: (_____) _____ E-mail Address: _____

Billing Address (if different from above) Street/P.O. Box: _____

City: _____ State: _____ ZIP: _____

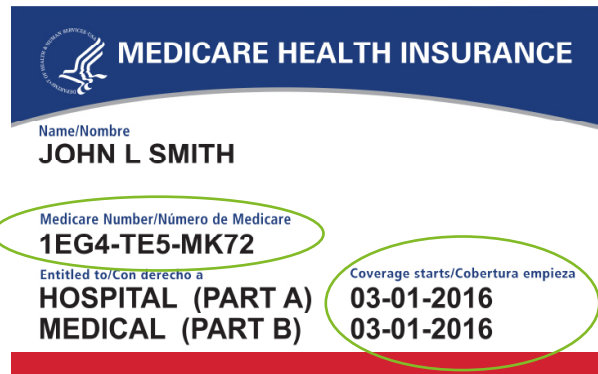
Section II – Medicare Information from Your Red, White, and Blue Medicare Card

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____

Hospital (Part B) Effective Date: _____

Note: You must be enrolled in Medicare Parts A and B to be eligible for coverage. Please provide a copy of your Medicare card or application if newly enrolled.





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Section III – Effective Date

Your effective date will be the 1st of the month after we receive your completed application and it is approved and processed. Upon approval, your effective date cannot be changed. If you provide a future effective date at right, it cannot be more than 90 days after the date we received your completed application or when first eligible for Medicare. **Note:** Effective date of coverage cannot be prior to your Medicare effective date.

If you want your coverage to start on a future date, enter date:

___ ___/01/ ___ ___ ___ ___
M M DD Y Y Y Y

Section IV – Plan Information

Select Plan: ___ Plan A ___ Plan C ___ Plan D ___ Plan F

___ Plan High Deductible F ___ Plan G ___ Plan High Deductible G ___ Plan N

Select payment option:

Automatic Payment Program. Mark this box if you would like your premium to be automatically deducted from your checking or savings account. If you choose this option, please complete the ACH contract. If this form is not enclosed, please call 1.877.847.7915 (TTY/TDD: 711).

Payment Coupons. Mark this box if you would like payment coupons mailed to you.

Section V – Guarantee Issue

1. Are you applying for coverage within six months of enrolling in Medicare Part B or within six months of your 65th birthday (commonly referred to as your initial Open Enrollment period)?

___ Yes ___ No

Are you applying for coverage under any guaranteed issue provision?
(See Guarantee Issue Guide) ___ Yes ___ No



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THP Medicare Supplement Insurance Coverage

Section V – Guarantee Issue (continued)

If yes, check which type and attach evidence of eligibility to this application.

2. Medicare Advantage disenrollment within 12 months of Part B eligibility.
3. Termination from Employee Welfare Benefit plan.
4. Relocation out of Medicare Advantage or Select service area.
5. Termination of Medicare Advantage, Medicare risk or cost contract or Med Select plan.
6. Loss of Medicare supplement due to insurer's insolvency, misrepresentation or breach of contract.
7. Previous Medicare supplement policy holder who voluntarily disenrolls to join for the first time a Medicare Advantage or Select plan and disenrolls within 12 months of enrolling in a Medicare Advantage or Select plan.

If you answered yes to any of these questions, please skip Section VI and go directly to Section VII to complete the application.

Section VI – Statement of Health

If you are applying for coverage during your Medicare Part B open enrollment or during a guaranteed issue period, **do not** complete this section. Refer to the Guaranteed Issue Guide for additional information.

Please call 1.877.847.7915 (TTY/TDD: 711) if you are a current member changing your coverage, to determine if you need to complete this section.

If the answer to any of the health questions 3–12 is "Yes," you are not eligible for coverage.

Height _____ft. _____in. Weight _____lbs.

1. __Yes __ No Have you used tobacco products within the last 10 years?

2. __Yes __No Were you eligible for Medicare before age 65? If yes, explain disability:

3. __Yes __No Are you currently confined, or has confinement been recommended, to a nursing facility, hospital, or other care facility, or do you need the assistance of a wheelchair?



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THP Medicare Supplement Insurance Coverage

Section VI – Statement of Health (continued)

4. Yes No Within the last 10 years, have you been advised to have a transplant, or a cardiac/heart operation or treatment, or any other surgery that has not yet been completed?

5. Yes No Within the last 10 years, have you been hospitalized two or more times?

6. Yes No Within the last 10 years, have you had or been advised to have kidney dialysis?

7. Yes No Within the last 10 years, have you been diagnosed or treated for Alzheimer's disease, dementia, senility, Parkinson's disease, multiple sclerosis, muscular dystrophy or amyotrophic lateral sclerosis (ALS)?

8. Yes No Within the last 10 years, have you been diagnosed or treated for internal cancer, malignant melanoma, leukemia, Hodgkin's disease, systemic lupus, cirrhosis of the liver, alcohol or drug abuse, acquired immune deficiency syndrome (AIDS) or AIDS related complex (ARC)?

9. Yes No Within the last 10 years, have you been diagnosed or treated for a heart attack, stroke, transient ischemic attack (TIA), heart valve surgery, congestive heart failure, peripheral vascular disease or enlarged heart?

10. Yes No Within the last 10 years, have you been diagnosed or treated for disabling arthritis or degenerative bone disease?

11. Yes No Within the last 10 years, have you been diagnosed or treated for emphysema, chronic obstructive pulmonary disease (COPD) or other chronic pulmonary disorders?

12. Yes No Are you an insulin-dependent diabetic?

13. Yes No Do you have any disease or disorder not mentioned above? If yes, please explain: _____

14. If answering YES to any of the questions in this section, please explain: _____



Ohio and West Virginia Application

THP Medicare Supplement Insurance Coverage

Section VI – Statement of Health (continued)

MEDICATION DETAILS

Current Medication Taken	Start Date, Strength, Frequency

Primary Care Physician: _____ Telephone: _____

Address: _____

Section VII – Current Health Coverage Information

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 insurance policies. Please include a copy of the notice from your prior insurer with your application.

Please answer all questions. Please mark “Yes” or “No” (below) with an “X” to the best of your knowledge:

1. (a) Yes No Did you turn age 65 in the last six months?

(b) Yes No Did you enroll in Medicare Part B in the last six months?

(c) If yes, what is the effective date? _____

2. Yes No Are you covered for medical assistance through the state Medicaid program? (Note to applicant: If you are participating in a “Spend-Down Program” and have not met your “Share of Cost,” please answer “No” to this question.

(a) If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No

(b) If yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? Yes No



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Section VII – Current Health Coverage Information (continued)

3. (a) 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.

Start: _____ **End:** _____

Plan name and telephone number: _____

(b) 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

(c) Was this your first time in this type of Medicare plan? Yes No

(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

4. (a) Yes No Do you have another Medicare Supplement policy in force?

(b) If yes, with what company, and what plan do you have? _____

(c) If so, do you intend to replace your current Medicare Supplement policy with this policy? Yes No

5. Yes No 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?

Plan name and telephone number:

(b) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "End" blank.

Start: _____ **End:** _____



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Section VIII – Household Premium Discount Information

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

1. Does a member of your household:

(a) to whom you are married or in a civil union partnership or

(b) who is a permanent resident of your household either

have an existing Medicare supplement plan with, or is applying for coverage with, THP Insurance Co., Inc. ?

Yes No

2. If you answered “YES” to Question 1 above, please fill out the following information about the household resident.

Name (First/Middle/Last): _____

Policy Number (if applicable): _____

Street Address: _____

City/State/ZIP: _____

Section IX – Conditions of Eligibility and Authorization

Before you apply, it is important that you read the following eligibility information and statements, then sign and date in the required place.

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 coverage.

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



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THP Medicare Supplement Insurance Coverage

Section IX – Conditions of Eligibility and Authorization (continued)

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.

5. If you are eligible for, and have enrolled in Medicare Supplement policy by reason of disability and you later become covered by 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 the suspension.

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

7. This application will become part of the policy for which you are applying.

8. You will receive no coverage under this plan unless THP approves this application. THP is not liable for bills incurred before the effective date of coverage. Cashing of your check or automatic bank draft does not constitute approval of your application.

9. Only THP can approve this application. A sales representative cannot grant approval, change terms or waive requirements.

10. Authorization for disclosures of personal information: I authorize any "provider of care," insurer or health plan to disclose to THP, or its representatives, all "medical information" (as those terms are defined in Ohio or West Virginia) regarding me, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits and/or for quality assurance and peer review. This authorization is effective immediately and shall remain for a period of 24 months, except that it shall remain effective for use with any claim for benefits for as long as THP coverage is in effect. A photocopy of this authorization is as valid as the original. My authorized representative and I are entitled to receive a copy of this authorization



Ohio and West Virginia Application

THP Medicare Supplement Insurance Coverage

Section IX – Conditions of Eligibility and Authorization (continued)

11. You may revoke this authorization at any time before you become a THP insured, except for instances that we have already taken action based on the authorization. Your revocation must be mailed to The Health Plan, 1110 Main Street, Wheeling, WV 26003.

I have read the Outline of Coverage and Conditions. I understand and agree to them. I alone am responsible for the accuracy and completeness of this application for health coverage.

I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

I understand that if I incur an illness or change in medical condition during the time between the date I sign this application and the effective date of coverage, I must notify THP Insurance Company in writing of any such illness or change, and such notice shall be a condition of my coverage. (This does not apply if I am applying during my open enrollment period or qualify for guaranteed-issue coverage for another reason).

I understand the eligibility information and have answered the questions in this application to the best of my knowledge. I certify that I meet the eligibility requirements outlined. I acknowledge that I have also received a copy of the "Guide to Health Insurance for People with Medicare" and an Outline of Coverage. I can expect to receive a copy of my completed application when my policy is issued to me if accepted for coverage. I understand that my copy of this application may be mailed separately from the policy.

Applicant's Full Signature: _____ Date: _____

Applicant's Full Name (please print): _____

Authorized Representative: _____ Date: _____

Durable Power of Attorney: Yes No If yes, attach copy of Durable Power of Attorney, if no, please explain: _____

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.



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Section X – Medicare Supplement (Agent completes – if applicable)

List policies sold to this applicant that are still in force: _____

List policies sold to this applicant in the past five years that are no longer in force: _____

I certify that the policy information listed above represents all health policies that I (or my agency) have sold to the applicant. (If none, so state) I certify that I asked all of the applicable questions and truly and accurately recorded the answers contained herein. I certify the applicant has read and the completed application or had it read to him or her.

Agent's Signature: _____ Date: _____

Agent's Full Name (please print): _____

Agent Number: _____ Agent Telephone Number: _____

Office Use Only

Effective Date of Coverage: _____ Date Received: _____

Group Number: _____ Automatic Payment Program: Yes No

Check Number: _____ Check Amount: \$_____

Date Copy of Accepted Application Mailed to Applicant: _____ By Whom: _____