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 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).
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.
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
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?

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 (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: ____________________________
______________________________________________________________________________________________________________________________________________________________
______________________________________________________________________________________________________________________________________________________________
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
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: ___________________________

Section VIII – 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 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 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 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 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.

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.
Section VIII – Conditions of Eligibility and Authorization (continued)

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.

Section IX – 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: _______________
Discrimination is Against the Law

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact The Health Plan Customer Service Department.

If you believe that The Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Health Plan Appeals Coordinator, 1110 Main Street, Wheeling, WV 26003, Phone: 1-877-847-7907, TTY: 711, Fax 740.699.6163, Email: info@healthplan.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance The Health Plan Customer Service Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1.800.368.1019, 1.800.537.7697 (TDD).


ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call 1-877-847-7907 (TTY: 711).


注意：如果您使用繁體中文，您可以免費獲得語言援助服務。
請致電 1-877-847-7907 (TTY: 711)