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.

The HealthPlan
HEALTHPLAN.ORG

FORM# OH: MS19A-OH

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.
- Age 65 or older.

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 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: _____

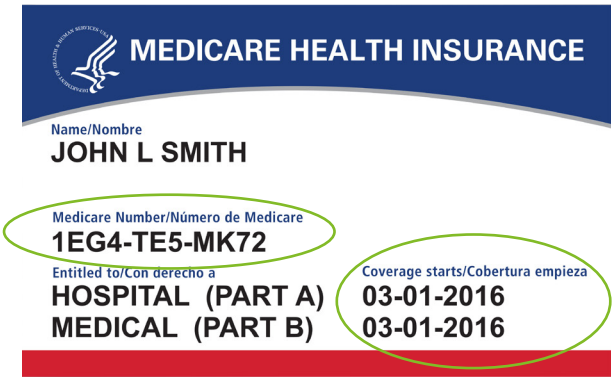
Section II – Medicare Information from Your Red, White, and Blue Medicare Card

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.



Ohio Application

THP Medicare Supplement Insurance Coverage

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

Ohio Application

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 eligilbility.
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?

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? Is yes, please explain: _____

_____

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

_____

_____

Ohio 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

Ohio Application

THP Medicare Supplement Insurance Coverage

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.

Section VIII – Conditions of Eligibility and Authorization (continued)

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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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.

Ohio Application

THP Medicare Supplement Insurance Coverage

Section VIII – Conditions of Eligibility and Authorization (continued)

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) 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.

Ohio Application

THP Medicare Supplement Insurance Coverage

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: _____

TheHealthPlan

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).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 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）

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-847-7907 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-847-7907 (رقم هاتف الصم والبكم: 711).

Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-877-847-7907 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-847-7907 (телетайп: 711).

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-847-7907 (ATS: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-847-7907 (TTY: 711).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-877-847-7907 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-847-7907 (TTY: 711).번으로 전화해 주십시오.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza lingüística gratuiti. Chiamare il numero 1-877-847-7907 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-847-7907 (TTY: 711) まで、お電話にてご連絡ください。

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-877-847-7907 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-877-847-7907 (телетайп: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-877-847-7907 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877- 847-7907 （TTY：711）.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-847-7907 (TTY: 711).

ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-877- 847-7907 (टिटिवाइ: 711)।

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877- 847-7907 (TTY: 711) تماس بگیرید.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877- 847-7907 (TTY: 711).

Revised 1/2020