APPLICATION FORM
Alliance Medicare Supplement Plan

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

Alliance Health and Life Insurance Company
Attn: Underwriting & Rating
2850 W. Grand Blvd.
Detroit, MI 48202

Call Toll-Free (800) 868-3153

Monday through Friday, 8 a.m. to 8 p.m.

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

E-mail Address (Optional)

Medicare Claim Number
(as shown on Medicare Health Insurance Card)

( ) Area Code Phone

Medicare Part A effective date (M M D D Y Y Y Y)

Medicare Part D effective date (M M D D Y Y Y Y)

2 SELECT THE ALLIANCE MEDICARE SUPPLEMENT PLAN THAT BEST MEETS YOUR NEEDS

You are eligible to apply for any of our Plans if you are a Medicare beneficiary, age 65 or older, enrolled in Medicare Parts A and B and you do not have more than one Medicare supplement policy.

If you will not reach age 65 by your coverage date, you are eligible to apply for Plan A or Plan C only (you are not eligible for Plan F, Plan G or Plan N). Please check the appropriate circle for the plan you are applying for:

○ Plan A ○ Plan C ○ Plan F ○ Plan G ○ Plan N

- Please refer to the enclosed brochure for the monthly cost of the plan and description of the plan offering.
- **Your coverage will become effective on the first day of the month following receipt and approval of your completed enrollment application. You will receive a Certificate of Insurance confirming your effective date. (If you would like your coverage to begin at a later date, please indicate below.)**

Requested Effective Date (first of the future month) (M M D D Y Y Y Y)
Your application must be received 30 days prior to your requested effective date.

Questions? Call Toll-Free (800) 868-3153 and talk to a HAP Medicare sales representative

3 YOUR ACCEPTANCE MAY BE GUARANTEED

	YES	NO
(a) Did you turn age 65 in the last 6 months?	❍	❍
(b) Did you enroll in Medicare Part B within the last 6 months?	❍	❍

If YES, what is the effective date? M M D D Y Y Y Y

If you answered YES to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP TO NUMBER 5.

(c) Have you lost other health insurance coverage and, if so, are you an eligible person as defined within the termination notice you received from your prior insurer? If the answer is "yes", you may be guaranteed acceptance in certain Alliance Medicare Supplement Plans. Please **include a copy of the termination notice** with your application and **SKIP TO NUMBER 5**.	❍	❍

If you answered YES to a, b or c above, you are applying for coverage during an open enrollment or guaranteed issue period. Please skip Section 4 and proceed to Section 5.

If you answered NO to a, b or c above, please proceed to Section 4.

4 COMPLETE SECTION 4 (This section does not apply if you are in the guaranteed issue or open enrollment period.)

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 check all that apply to you:		
Diagnosed with End Stage Renal (kidney) Disease (ESRD)	❍	❍
The kidney disease will require dialysis	❍	❍
Receiving dialysis	❍	❍
Been hospitalized overnight in the last 90 days	❍	❍
(c) In the past two years, have you used tobacco in any form?	❍	❍

(d) Height_____ Weight_____lbs

(e) Have you, due to mental or physical disability, authorized any person or institution to legally act in your behalf and take over your personal business transactions?	❍	❍

If yes, please provide name & relationship.

_____

(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_____

_____

(g) In the past 12 months, have you been hospitalized as an inpatient?	❍	❍

If yes, please explain: _____

(h) Do you visit any medical provider more than monthly for medical advice or treatment?	❍	❍

If yes, please explain: _____

_____

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4 HEALTH INFORMATION (CONTINUED)

	YES	NO
(i) In the past 2 years, have you been diagnosed or treated or have you been advised to be treated for:		
(1) Cancer (except basal cell skin cancer) or leukemia	❍	❍
(2) Chronic Lung Disease, COPD, emphysema	❍	❍
(3) Cirrhosis of the liver, any liver or pancreas disease	❍	❍
(4) Diabetes (insulin dependent) neuropathy, kidney disorder, retinopathy or amputation	❍	❍
(5) Stroke, clotting disorder	❍	❍
(6) Angina Pectoris, Heart Attack, Congestive Heart Failure, or Valvular Heart Disease, heart disease, atrial fibrillation, pacemaker, carotid artery disease	❍	❍
(7) Alzheimer's Disease	❍	❍
(8) Parkinson's Disease, ALS (Lou Gehrig's Disease)	❍	❍
(9) Multiple Sclerosis, quadriplegia, hemiplegia or paralysis	❍	❍
(10) Organ or bone marrow transplant	❍	❍
(11) Systemic lupus, joint replacement and/or back/spine surgery	❍	❍
(j) Are you taking prescription medications?	❍	❍
If yes, please list medications and the conditions for which they are taken: _____		
(k) When was your last doctor visit?	❍	❍
Date:_____ Reason for visit: _____		
Tests performed: _____		
Test results or recommendations:_____		
(l) Do you have any other medical conditions not previously mentioned?	❍	❍
If Yes, please provide details, treatment, dates, and current status. _____		
_____		

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

To: Any licensed physician, medical practitioner, hospital, pharmacy, clinic, or like facility; insurance company; or other organization, institution, or person. I authorize you to give Alliance Health and Life Insurance Company any data or records you may have about me or my mental or physical health. Alliance Health and Life Insurance Company needs this data to find out if I qualify for health insurance and to administer my coverage if accepted. For purposes of determining my qualification for coverage, this authorization is valid for 24 months from the date of my signature. For claims processing, this authorization is valid for the term of the coverage.

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

✗ _____ _____

YOUR SIGNATURE (REQUIRED) DATE (REQUIRED) M M D D Y Y Y Y

✗ _____ _____

AGENT (NAME REQUIRED) DATE (REQUIRED) M M D D Y Y Y Y

5 FOR YOUR PROTECTION YOU ARE REQUIRED TO READ THE STATEMENTS BELOW, ANSWER ALL THE QUESTIONS AND SIGN WHERE INDICATED

(1) You do not need more than 1 medicare supplement policy.

(2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(3) If you are eligible for Medicaid, you may not need a medicare supplement policy.

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5 (CONTINUED)

(4) 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.

(5) 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.

(6) 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 be guaranteed acceptance in one or more of our medicare supplement plan.

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

		YES	NO
(1)	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.)	❍	❍
	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) (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 _____/_____/_____		
(b)	If you are still covered under the medicare plan, do you intend to replace your current coverage with this new medicare supplement policy?	❍	❍
(c)	Was this your first time in this type of medicare plan?	❍	❍
(d)	Did you drop a medicare supplement policy to enroll in the medicare plan?	❍	❍
(3) (a)	Do you have another medicare supplement policy in force?	❍	❍
(b)	If so, 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?	❍	❍
(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 so, with what company and what kind of policy? _____		
(b)	What are your dates of coverage under the other policy? START _____/_____/_____ END _____/_____/_____ (If you are still covered under the other policy, leave "END" blank.)		

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6 IF THIS POLICY IS SOLD BY AN 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 _____

7 IMPORTANT ACKNOWLEDGMENT. AUTHORIZATION AND VERIFICATION INFORMATION. PLEASE READ CAREFULLY, SIGN AND DATE WHERE INDICATED.

- My signature below indicates that I have read and understand the contents of this application.
- I acknowledge receipt of the Alliance Medicare Supplement product brochure (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.

Authorization: for the Release of Medical Information.

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

X _____		
YOUR SIGNATURE (REQUIRED)	DATE (REQUIRED)	M M D D Y Y Y Y
X _____		
AGENT (NAME REQUIRED)	DATE (REQUIRED)	M M D D Y Y Y Y

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