MEDMUTUAL PROTECT®
A Medical Mutual® Company

Insurance benefits provided by:
MedMutual Life Insurance Company
State of Domicile: Ohio
Cleveland, OH
Administrative Office: PO Box 10862
Clearwater, FL 33757-8862
M-MCS-APP-24-UT

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE COVERAGE

(Check one)	☒ New Business	☐ Reinstatement Policy #:	☐ Conversion Policy #:

SECTION 1. PROPOSED INSURED INFORMATION **APPLICATION #**

Applicant Name *(exactly as it appears on your Medicare Card)*

First Name	Middle Initial	Last Name
Resident Address		
City	State	Zip Code
Phone *(with area code)*	Email Address	
Age *(as of requested effective date)*	Date of Birth *(MM/DD/YYYY)*	
Height (*Feet and inches*)	Weight (*Pounds*)	Male ☐ Female ☐
Social Security Number	Medicare Number	
Date Enrolled in Medicare Part A *(MM/DD/YYYY)*		
Date Enrolled in Medicare Part B *(MM/DD/YYYY)*		
Have you enrolled in Medicare Part B more than once?		Yes ☐ No ☐

SECTION 2. PLAN AND PREMIUM INFORMATION

Plan Applied For	Requested Policy Effective Date
Household Premium Discount Yes ☐ No ☐ *If you answered Yes, please complete the Household Questions in Section 6.*	
Modal Premium $	Premium Collected $ Policy Fee $
Payment Method:	Bank Draft ☐ Direct Bill ☐
Payment Mode: Monthly ☐ *(Bank Draft ONLY)* Annual ☐ Semi-Annual ☐ Quarterly ☐	

SECTION 3. PLEASE ANSWER ALL ELIGIBILITY QUESTIONS

1. Are you applying during a guaranteed issue period? *(If YES you must attach proof of eligibility).* Yes ☐ No ☐

SECTION 4. HEALTH QUESTIONS

Applicants eligible for GUARANTEED ISSUE or OPEN ENROLLMENT, go to Section 5. If not, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

Within the past 12 months, have you used any tobacco products, including cigarettes, cigars, eCigarettes, chewing tobacco, or a pipe? Yes ☐ No ☐

IF THE ANSWER TO ANY PART OF QUESTIONS #1-9 IN THIS SECTION IS YES, THE APPLICANT IS NOT ELIGIBLE FOR COVERAGE.

1. Are you currently bedridden, confined to a wheelchair, or do you require the assistance of a motorized mobility device? Yes ☐ No ☐
2. Are you currently hospitalized, in a nursing home or assisted living facility, using the services of a home healthcare agency or have you been hospitalized two or more times in the past year? Yes ☐ No ☐
3. In the past two years, have you been advised to have surgery (including cataract or joint replacement surgery), injections in a physician's office, infusions, or therapy that has not been performed? Yes ☐ No ☐
4. Within the past ten years, have you had, been medically diagnosed with, or treated for any of the following:
   a. Parkinson's disease, multiple or amyotrophic lateral sclerosis, muscular dystrophy, Alzheimer's disease, dementia, or any other cognitive disorder? Yes ☐ No ☐
   b. Acquired Immune Deficiency Syndrome (AIDS), AIDS related complex (ARC), or tested positive for the Human Immunodeficiency Virus (HIV)? Yes ☐ No ☐
   c. Chronic kidney disease or insufficiency, or renal failure requiring dialysis? Yes ☐ No ☐
   d. Emphysema, chronic obstructive pulmonary disease (COPD), or any other chronic pulmonary condition, or any medical condition requiring the use of oxygen? Yes ☐ No ☐
   e. Systemic Lupus, scleroderma, myasthenia gravis, or Crohn's Disease or Ulcerative Colitis? Yes ☐ No ☐
   f. An organ transplant, stem cell transplant or been advised to have an organ transplant (excluding cornea transplants)? Yes ☐ No ☐
   g. Chronic hepatitis or cirrhosis of the liver? Yes ☐ No ☐
   h. Cardiac defibrillator implanted? Yes ☐ No ☐
   i. Osteoporosis with fractures? Yes ☐ No ☐
   j. Aortic or cardiac aneurysm that has not been surgically repaired**?** Yes ☐ No ☐
5. Within the past two (2) years, have you had any of the following:
   a. Heart attack, cardiac angioplasty, bypass surgery, or stent placement or replacement? Yes ☐ No ☐
   b. Vascular angioplasty, endarterectomy, or implantation of a pacemaker? Yes ☐ No ☐
   c. A stroke or transient ischemic attack (TIA)? Yes ☐ No ☐

SECTION 4. HEALTH QUESTIONS (continued)

6. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment for:
   a. Alcoholism or drug abuse? Yes ☐ No ☐
   b. Internal cancer (examples include but are not limited to breast, lung or liver cancer, etc.), leukemia, melanoma, Hodgkin's disease, or lymphoma? Yes ☐ No ☐
   c. Any mental or nervous disorder requiring inpatient treatment by a psychiatrist? Yes ☐ No ☐

7. Within the past two (2) years have you had or been treated for or been advised by a physician to have treatment of the following:

   - Coronary artery disease
   - Cardiomyopathy
   - Congestive heart failure
   - Angina
   - Peripheral artery disease
   - Peripheral vascular disease
   - Peripheral venous thrombotic disease
   - Carotid artery disease
   - Neuropathy

   Yes ☐ No ☐

8. Within the past twelve (12) months have you had or been treated for or been advised by a physician to have treatment of the following:

   If YES please answer each of the following questions (a-b); if NO, go to Question 9.

   - Degenerative bone disease
   - Spinal stenosis
   - Rheumatoid arthritis
   - Heart valve disorder
   - Atrial fibrillation
   - Heart rhythm disorder
   - Pancreatitis

   Yes ☐ No ☐

   a. Have you visited a hospital or urgent care in the last year for the above listed conditions? Yes ☐ No ☐
   b. Have you been prescribed or taken any new medication or increased dosage in the last year for any of the above listed conditions? Yes ☐ No ☐

9. Do you take insulin to control diabetes? Yes ☐ No ☐

SECTION 5. REPLACEMENT QUESTIONS

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.

1. To the Best of Your Knowledge:
   (a) Did you turn age 65 in the last six (6) months? Yes ☐ No ☐
   (b) Did you enroll in Medicare Part B in the last six (6) months? Yes ☐ No ☐
   (c) If YES, indicate your effective date (*MM/DD/YYYY*) _____
2. Are you covered for medical assistance through the state Medicaid program? Yes ☐ No ☐

   (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to the above question.)

SECTION 5. REPLACEMENT QUESTIONS (Continued)

If YES, answer (a) – (b) below.

(a) Will Medicaid pay your premiums for this Medicare supplement policy? Yes ☐ No ☐

(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes ☐ No ☐

3. Have 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.) Yes ☐ No ☐

If YES, answer (a) – (g) below.

(a) Name of Company .....

Plan Type & Policy/Certificate No .....

Company Telephone Number .....

Coverage Dates (*MM/DD/YYYY*) START DATE _____

Enter date coverage will be canceling or ending. END DATE _____

(if you are still covered under this plan, leave end date blank) _____

(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 ☐

If YES, have you completed and received a copy of the replacement notice? Yes ☐ No ☐

(c) Reason for termination/disenrollment? .....

(d) Planned date of termination/disenrollment? (*MM/DD/YYYY*) _____

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

(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? Yes ☐ No ☐

(g) Is your former Medicare supplement or Medicare select policy/certificate still available? Yes ☐ No ☐

4. Do you have another Medicare Supplement or Medicare Select insurance policy in force? Yes ☐ No ☐

If YES, answer (a) – (d) below.

(a) Name of Company .....

Plan Type & Policy/Certificate No .....

Company Telephone Number .....

Issue Date (*MM/DD/YYYY*) _____

(b) Do you intend to replace your current Medicare supplement or Medicare select policy/certificate with this policy? Yes ☐ No ☐

(c) Indicate termination date (*MM/DD/YYYY*). _____

(d) Have you completed and received a copy of the replacement notice? Yes ☐ No ☐

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) Yes ☐ No ☐

If YES, answer (a) – (c) below.

(a) Name of Company .....

Plan Type & Policy/Certificate No .....

Company Telephone Number .....

Coverage Dates (*MM/DD/YYYY*): START DATE _____

(if you are still covered under this plan, leave end date blank) END DATE _____

(b) Reason for termination/disenrollment? .....

(c) Planned date of termination/disenrollment (*MM/DD/YYYY*)? _____

SECTION 6. 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. Do you currently have a household resident (at least one, no more than three) with whom you have continuously resided for the last 12 months? 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)

Date of Birth

Street Address

City/State/Zip

SECTION 7. OTHER POLICIES SOLD BY AGENT TO APPLICANT

Agent shall list any other health insurance policies he/she has sold to the applicant.

(1) List all health insurance policies sold to the Applicant which are still in force.

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

(2) List all health insurance policies sold in the last five (5) years which are no longer in force.

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

SECTION 7. OTHER POLICIES SOLD BY AGENT TO APPLICANT (Continued)

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

Name of Company

Type of Policy

Policy/Certificate Number

Effective Date of Coverage

SECTION 8. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- 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 if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance Policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance 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.
- 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. 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.
- Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance policy and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

SECTION 9. ELECTRONIC AND/OR TELEPHONIC INSTRUCTIONS

Authorization is requested by the Company to act on electronic and/or telephonic instructions from the applicant. Proper identification must be provided. The Company will be held harmless for any claim, liability, loss or cost, when it has used reasonable procedures to confirm these transactions are authorized and genuine and these procedures have been followed (Check One).

☐ I authorize the Company to act on electronic and/or telephonic instructions. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation and that there are no consequences if consent is withdrawn.

☐ I DO NOT authorize the Company to act on electronic and/or telephonic instructions.

Authorization is requested by the Company for the electronic delivery of statements and other documents (Check One).

☐ I authorize the Company to electronically deliver statements and other documents. I do have access to the Internet for the purposes of accepting electronic delivery of the documents and a means by which I can provide a current Internet email address. I acknowledge that, should I desire to revoke this written authorization, I will inform the Company, in writing, of such revocation and that there are no consequences if consent is withdrawn.

☐ I DO NOT authorize the Company to electronically deliver statements and other documents.

Note: I acknowledge that I am responsible for notifying the Company in the event that the email address should change and that I have the option to receive written communication in paper form. If the Company receives a return message as undeliverable each time electronic delivery is attempted over two business days, it will be presumed consent has been withdrawn.

SECTION 10. AGREEMENT AND AUTHORIZATION

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete as written and are correctly recorded and I understand and agree that: (a) the insurance shall not take effect until my Medicare coverage is effective, the application has been accepted and approved by the Company, the first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

The undersigned applicant certifies that the applicant has read, or had read to him, the completed application and that he realizes that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part. I understand that any change in my health history prior to delivery of this policy may be used in the underwriting evaluation process.

Notice: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

I wish to apply for a Medicare Supplement insurance policy. I acknowledge that I have received or been given access to review or print: (a) an Outline of Coverage for the policy applied for, and (b) a "*Guide to Health Insurance for People with Medicare*."

Authorization for Use and Disclosure of Protected Health Information: In connection with an application for insurance made to MedMutual Life Insurance Company (the "Company"), I, the undersigned Applicant, authorize the use and disclosure of protected health information about me as described below.

SECTION 10. AGREEMENT AND AUTHORIZATION (Continued)

1. I understand that this authorization is necessary for the Company to determine my eligibility for insurance as part of the Company's underwriting and risk rating determinations. I understand that my application for insurance may be declined if I do not sign this authorization
2. The following class of persons is authorized to make the disclosure: All physicians, medical practitioners, health professionals, hospitals, clinics, medical facilities, pharmacy benefit managers, pharmacy related service organizations, the Veterans Administration, reinsurers, consumer reporting agencies, or insurance support organizations.
3. The Company, its agents, employees, and third-party administrators may receive my protected health information.
4. The protected health information that should be disclosed to the Company is: All my health records and information about my past, present or future physical or mental health or condition, health care I have received, and any related diagnosis, treatment or prognosis, including, but not limited to, any records that may relate to (a) psychological or psychiatric conditions (excluding psychotherapy notes), (b) drug abuse, (c) alcoholism, (d) sickle cell anemia, (e) tuberculosis or (f) communicable or venereal diseases which may include, but are not limited to, hepatitis, syphilis, gonorrhea, human immunodeficiency virus, acquired immune deficiency syndrome (AIDS) and AIDS related complex (excluding information about previously administered tests for t-cell counts, HIV antibodies, AIDS or ARC).
5. I understand that the protected health information used or disclosed will not be redisclosed by the Company without my prior written authorization, unless permitted or required by federal privacy regulations or other applicable law. In the event of redisclosure of such information, it may then no longer be protected by federal privacy regulations.
6. I may revoke this authorization with respect to a recipient by notifying that recipient in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and any revocation will not affect those actions.
7. A photocopy of this authorization shall be considered as valid as the original.
8. This authorization expires 24 months after the date signed by me.
9. I understand that a copy of this authorization will be furnished to me or my authorized representative upon request.

I have paid to MedMutual Life Insurance Company the amount shown on Page 1 of this application, and I hold a receipt for that amount made up without alteration bearing the same date as this application.

Signed at:

State	Printed Name of Applicant	Signature of Applicant	Date

SECTION 11. AGENT CERTIFICATION

I certify that: (1) I have asked each question of the Applicant personally; (2) I have accurately recorded the information supplied by the Applicant; and (3) I have reviewed the current health coverage of the Applicant and have completed the information above, as applicable.

Agent Writing Number | Printed Name of Agent | Agent Signature | Date

Policy Mailing Preference: ☐ Mail to Agent ☐ Mail to Applicant