35674

INDIVIDUAL COVERAGE APPLICATION FORM

AmeriHealth Medigap Plans are underwritten by AmeriHealth Insurance Company of New Jersey.

To apply for AmeriHealth Medigap Plans

Please reference the enclosed AmeriHealth Medigap Plans Outline of Coverage for the monthly premium based on your plan.

1. You must have Medicare Part A and Part B to join AmeriHealth Medigap Plans.

Check the ONE plan for which you are enrolling:

☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan N

Please check desired billing cycle:

☐ Monthly
☐ Bi-monthly
☐ Quarterly

Exceptions apply. Please see section D for "Open Enrollment/Guaranteed Issue Period Information"

Desired effective date: ☐☐-0 1-☐☐☐☐
MM DD YYYY

LAST Name: FIRST Name: Middle Initial: S.S.#: ☐☐☐-☐☐-☐☐☐☐

Birth Date: ☐☐-☐☐-☐☐☐☐
M M D D Y Y Y Y

Sex: ☐ M ☐ F

Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Permanent Residence Street Address:

City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Emergency Contact: ______________________________

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Relationship to You:** ____________________

Email Address (optional): ____

By giving us your email address and providing your signature in the designated box, you are providing permission for us to contact you via email with information related to your health benefits, additional products, services and/or educational information related to your health care. Providing your email address is optional.

Please provide your Medicare insurance information

Please take out your Medicare card to complete this section.

- Please fill in these blank boxes so that they match your red, white, and blue Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

Underwriting Risk Classification Question

Have you used any form of tobacco at any time within the last 12 months? .... ☐ Yes ☐ No

(You do not have to answer this question if you are applying during an Open Enrollment or a Guaranteed Issue period.)

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: John Q. Sample

Medicare Claim Number

☐☐☐☐☐☐☐☐☐ ☐☐

Is Entitled To	Effective Date
HOSPITAL (Part A)	☐☐-☐☐-☐☐☐☐
MEDICAL (Part B)	☐☐-☐☐-☐☐☐☐

MEDICAL COVERAGE REPLACEMENT (Must be completed)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. 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. Did you turn age 65 in the last 6 months? .... ☐ Yes ☐ No

2. Did you enroll in Medicare Part B in the last 6 months? .... ☐ Yes ☐ No

   If yes, what is the effective date? ☐☐-☐☐-☐☐☐☐
   MM DD YYYY

3. 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 this question.

   If yes, will Medicaid pay your premiums for this Medicare supplement policy? .... ☐ Yes ☐ No

   Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? .... ☐ Yes ☐ No

4. If you had coverage from any Medicare plan other than Original Medicare within the last 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** ☐☐-☐☐-☐☐☐☐
   MM DD YYYY MM DD YYYY

MEDICAL COVERAGE REPLACEMENT (Must be completed, continued)

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

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

Did you drop a Medicare supplement policy to enroll in the Medicare Plan? ☐ Yes ☐ No

If currently enrolled in a Medicare Advantage plan, your Medigap Plan effective date should start upon the date your Medicare Advantage plan coverage will end.

5. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No

   If yes, with what company and what plan do you have? ______________________

   If yes, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

6. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

   If yes, with what company and what kind of policy? ______________________

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

   START ☐☐-☐☐-☐☐☐☐ (MM DD YYYY) **END** ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

GUARANTEED ACCEPTANCE/OPEN ENROLLMENT DETERMINATION

For a description of guaranteed issue and open enrollment, please see section D.
PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE.

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ☐ Yes ☐ No
   If yes, please go to section E. If no, continue to the next section.

2. Have you lost, or are you losing, other health coverage which would qualify you for guaranteed acceptance? ☐ Yes ☐ No
   If yes, please go to section E. If no, continue to the next section.

HEALTH QUESTIONS

You are *not required* to answer health questions 1-10 if you are in an Open Enrollment or a Guaranteed Issue period. Please see Section D for an explanation of Open Enrollment/Guaranteed Issue period information.
If you answer "yes" to any of the health questions 1-10, you are not eligible for coverage.

Please mark Yes or No below with an X.

1. Are you dependent on a wheelchair or any motorized mobility device? ☐ Yes ☐ No

2. Do any of the following apply to you?
   Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy ☐ Yes ☐ No

3. At any time, have you been medically diagnosed, treated, hospitalized, or had surgery for any of the following?
   A. congestive heart failure, unoperated aneurysm, defibrillator ☐ Yes ☐ No
   B. leukemia, lymphoma, multiple myeloma, cirrhosis ☐ Yes ☐ No

HEALTH QUESTIONS (continued)

C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy ☐ Yes ☐ No

D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease ☐ Yes ☐ No

E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant ☐ Yes ☐ No

F. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), tested positive for the Human Immunodeficiency Virus (HIV) ☐ Yes ☐ No

4. Do you have diabetes?

A. that requires use of insulin ☐ Yes ☐ No

B. with complications, including retinopathy, neuropathy, peripheral vascular or arterial disease, or heart artery blockage ☐ Yes ☐ No

C. with history of heart attack or stroke (at any time) ☐ Yes ☐ No

D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar ☐ Yes ☐ No

5. Within the past 36 months, have you been medically diagnosed, treated, hospitalized, or had surgery for any of the following?

A. alcoholism, drug abuse ☐ Yes ☐ No

B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, or any other blood disorder ☐ Yes ☐ No

C. internal cancer, melanoma, Hodgkin's Disease ☐ Yes ☐ No

D. hepatitis, disorder of the pancreas ☐ Yes ☐ No

6. Within the past 24 months, have you been medically diagnosed, treated, hospitalized, or had surgery for any of the following?

A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease ☐ Yes ☐ No

B. myasthenia gravis, systemic lupus or connective tissue disorder ☐ Yes ☐ No

C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living ☐ Yes ☐ No

D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder ☐ Yes ☐ No

E. any lung or respiratory disorder and currently use tobacco products ☐ Yes ☐ No

7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed? ☐ Yes ☐ No

8. Within the past 12 months, have you been medically diagnosed, treated, hospitalized, or had surgery for a heart attack, artery blockage, or heart valve disorder? ☐ Yes ☐ No

9. Within the past 12 months, do any of the following apply to you?

A. had a pacemaker implanted ☐ Yes ☐ No

B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer ☐ Yes ☐ No

C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer ☐ Yes ☐ No

D. had a seizure ☐ Yes ☐ No

10. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic? ☐ Yes ☐ No

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

Physician Information

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

Primary Physician:		Phone: ☐☐☐-☐☐☐-☐☐☐☐
Physician's Office Name:	City:	State:

Specialist seen in the past 24 months:	Specialty
Reason for Seeing (diagnosis)	
Specialist seen in the past 24 months:	Specialty
Reason for Seeing (diagnosis)	
Specialist seen in the past 24 months:	Specialty
Reason for Seeing (diagnosis)	

Have you seen any additional physicians other than those listed above in the past 24 months? .... ☐ Yes ☐ No

IMPORTANT NOTICE — please read carefully

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 policy.

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 the Medicare supplement policy 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 Medicare supplement insurance 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).

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-10 on pages 3 and 4 of this application if (a) you are within 6 months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within 6 months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

IMPORTANT NOTICE (continued)

(a) Enrolled under an employee welfare benefit plan that either: (1) supplements Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan; or

(b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or

(c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material police provision, or a material misrepresentation was made to the individual; or

(d) Enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage under the policy, substantial violation of material policy provision, or material misrepresentation; or

(e) Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage plan, a risk or cost contract, a Medicare Select plan, or a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or

(f) Upon first becoming eligible for benefits under Part A at age 65, you enrolled in a Medicare Advantage plan or PACE provider and then you disenroll within 12 months; or

(g) Enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under Medicare Supplement policy that covers outpatient prescription drugs and terminated enrollment in the Medicare Supplement policy, and submits evidence of enrollment in Medicare Part D along with the application for Plan A, C, F, or N.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION AND CONFIRMATION

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, the Veterans Administration or other medical or medically related facility, insurance company or other organization, institution or person, including Medicare, that has any records or knowledge of me or my health or having any non-medical information concerning me to give AmeriHealth Insurance Company of New Jersey, or its reinsurers, any such information. I understand that I am authorizing AmeriHealth Insurance Company of New Jersey to receive my health information, prescription drug usage history, and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. The released information received by AmeriHealth Insurance Company of New Jersey will remain protected by federal and/or state regulations as long as it is maintained by the health plan. Medical information will not be used to decline coverage if I am applying during an Open Enrollment or Guaranteed Issue period.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Medicare Supplement Insurance Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with AmeriHealth Insurance Company of New Jersey. I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to AmeriHealth Insurance Company of New Jersey will result in the rejection of the Medicare Supplement Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying AmeriHealth Insurance Company of New Jersey in writing at AmeriHealth Insurance Company of New Jersey, [P.O. Box 7576, Philadelphia, PA 19101-7576. I understand that such revocation will not have any effect on actions AmeriHealth Insurance Company of New Jersey took prior to their receiving the revocation notice. I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

AUTHORIZATION AND CONFIRMATION (continued)

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full 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.

ANY PERSON WHO INCLUDES FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and (b) a "Guide to Health Insurance for People with Medicare."

Signed at: ______________________________________
(City/State)

Dated: ____________________________ Applicant's Signature: __________________________________
(Month/Day/Year)

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold the Applicant that is still in force.

   ____

   ____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

   ____

   ____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an Outline of Coverage for the policy applied for and a Guide to Health Insurance for People with Medicare to the Applicant.

__________________________________ __________________________________
Agent's Signature: Date:

__________________________________ __________________________________
Agent's Printed Name: Agent No:

AmeriHealth Medigap Plans
P.O. Box 7576
Philadelphia, PA 19101-7576

AmeriHealth Medigap Plans are not connected with or endorsed by the U.S. government or the federal Medicare program.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by AmeriHealth Insurance Company of New Jersey. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

☐ **Additional benefits.**

☐ **No change in benefits, but lower premium.**

☐ **Fewer benefits and lower premiums.**

☐ **My plan has outpatient prescription drug coverage and I am enrolling in Part D.**

☐ **Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:**

____

____

☐ **Other. (please specify)** ____

____

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

____**: Signature of Producer or other representative**

____**: Applicant Signature & Date**

AmeriHealth Medigap Plans are underwritten by AmeriHealth Insurance Company of New Jersey.