MEDICAL MUTUAL®

doing business as Medical Health Insuring Corporation of Ohio

Medicare Supplement Plan Enrollment Application

Important Information

- 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 twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no long 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 ninety (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 the 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 ninety (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.
- 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).

For Internal Use Only			
Effective Date	**Group Number**	**Sold (Account Executive and Code)**	**Service (Account Executive and Code)**

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Section 1: Contract Holder Information

Last Name	MI	First Name	Social Security Number

Birthdate	Sex ☐ Male ☐ Female		Phone Number

Address	County

City	State	ZIP Code	Email Address

Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date

Section 2: Effective Date

The effective date for your Medicare Supplement Plan is the first of the month following Medical Mutual's receipt of the completed application. When should coverage start:	Effective Date

Section 3: Products

Please select a Medicare Supplement Plan option (Check only one):
☐ Medicare Supplement Plan A ☐ Medicare Supplement Plan C ☐ Medicare Supplement Plan F
☐ Medicare Supplement High-Deductible Plan F ☐ Medicare Supplement Plan G
☐ Medicare Supplement Plan N

Section 4: Billing Information

Please indicate how you would prefer to pay your premiums (Choose one).
☐ **1. Home** (Receive monthly premium billings)*
☐ **2. Different Billing Address** (Have home billing sent to a different address)
If your mailing address is different than your permanent address, please complete the following:

Last Name (C/O)	First Name	MI

Address	City	State	ZIP Code

☐ **3. Financial Institution** (Automatic monthly premium withdrawals)
If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from my:
☐ Checking Account* ☐ Savings Account*

Account Holder Name

Account Number	Transit Routing Number

Attach cancelled check or deposit slip here.

* **Please Note**: Not all financial institutions allow deductions from a savings account. Please verify this information with your financial institution. In case of insufficient funds a $25 returned item fee may be applied.

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Section 5: Other 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 plans. Please include a copy of the notice from your prior insurer with your application. **Please answer all questions to the best of your knowledge.**

☐ **Yes** ☐ **No** 1. (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? If "Yes," what is your effective date?

Effective Date	

☐ **Yes** ☐ **No** 2. Are you covered for medical assistance through the state Medicaid Program?
Note: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "No" to this question.

3. I had coverage within the past 63 days and that coverage **involuntarily** ended because:

☐ **Yes** ☐ **No** (a) My employer group health plan (including retiree or COBRA coverage) or union coverage (that paid after Medicare paid) stopped offering me coverage.

If 3a was answered as Yes, answer question 7 and skip questions 4, 5, and 6.

☐ **Yes** ☐ **No** (b) My insurance carrier stopped offering the Medigap/Medicare Supplement product that I was enrolled with.

If 3b was answered as Yes, answer question 7 and skip questions 4, 5 and 6.

☐ **Yes** ☐ **No** (c) I moved out of the service area for the plan that I was covered with.

If 3c was answered as Yes, answer question 7 and skip questions 4, 5 and 6.

☐ **Yes** ☐ **No** (d) I decided to switch to Original Medicare within the first year of joining the PACE or Medicare Advantage program.

If 3d was answered as Yes, answer question 7 and skip questions 4, 5 and 6.

☐ **Yes** ☐ **No** 4. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g. 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 Date" blank.

Start Date	End Date	

☐ **Yes** ☐ **No** (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 with this policy to enroll in the Medicare plan?

continued on next page

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Section 5: Other Coverage Information (cont.)

☐ **Yes** ☐ **No** 5. (a) Do you have another Medicare supplement policy in force? If so, what company and what plan do you have?

Company	Plan

☐ **Yes** ☐ **No** (b) If you answered "Yes" to 5a, do you intend to replace your current Medicare Supplement policy with this policy?

☐ **Yes** ☐ **No** 6. (a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual health plan). If so, what company and what plan do you have?

Company	Plan

(b) If you answered "Yes" to 6a, what are your dates of coverage under the policy? If you are still covered under the policy, leave "End Date" blank.

Start Date	End Date	

☐ **Yes** ☐ **No** 7. Agent shall list any other health insurance policies agent has sold to the applicant.
(a) List policies sold which are still in force.
☐ **Yes** ☐ **No** (b) List policies sold in the past five (5) years which are no longer in force.
(c) Are you still covered?
(d) Do you intend to replace your current coverage with this new Medicare Supplement policy?

Company Name (if applicable)	Plan Name (if applicable)

Start Date	End Date	

Name of Plan	Type of Coverage	Start Date	End Date

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Section 6: Medical Eligibility

IMPORTANT NOTICE: You do not have to complete this section if:

- This application is being submitted within six (6) months from the month in which you first enrolled for benefits under Medicare Part B. **OR**
- You have answered Yes to the following questions in Section 5 of this application, 3a, 3b, 3c or 3d.

☐ **Yes** ☐ **No**	1. Have you been hospitalized two (2) or more times within the past 12 months?
☐ **Yes** ☐ **No**	2. Are you currently confined to a hospital, skilled nursing facility, extended care facility, wheel chair or have you been so confined for more than five consecutive days within the last twelve months?
☐ **Yes** ☐ **No**	3. Have you been advised that you will need to be admitted to a hospital, skilled nursing facility or extended care facility within the next six (6) months or have any condition for which surgery is pending?
☐ **Yes** ☐ **No**	4. Within the past three years have you been treated for or diagnosed as having AIDS, ARC or HIV?

5. Within the past five years have you been treated for, diagnosed as having, or been recommended for future surgery, diagnostic testing or medical treatment, or thought you should seek medical advice for any of the following conditions?

☐ **Yes** ☐ **No**	Cirrhosis of the Liver
☐ **Yes** ☐ **No**	Parkinson's Disease
☐ **Yes** ☐ **No**	Stroke or Transient Ischemic Attack (TIA)
☐ **Yes** ☐ **No**	End-Stage Renal Disease or Dialysis
☐ **Yes** ☐ **No**	Systemic Lupus
☐ **Yes** ☐ **No**	Cancer – *If Yes:* ☐ **Yes** ☐ **No** Are you currently in treatment? *If No*, answer question 5a below.
☐ **Yes** ☐ **No**	Organ Transplant– *If Yes:* ☐ **Yes** ☐ **No** Was it a Corneal only transplant? *If Yes*, answer question 5a below.
☐ **Yes** ☐ **No**	Heart Disease– *If Yes:* ☐ **Yes** ☐ **No** Have you had an angioplasty/stent bypass surgery, valve replacement, defibrillator/pacemaker, or have been diagnosed with a heart attack, congestive heart failure or cardiomyopathy? *If No*, answer question 5a below.
☐ **Yes** ☐ **No**	Aneurysm (any kind)– *If Yes:* ☐ **Yes** ☐ **No** Was the aneurysm corrected via surgery? *If Yes*, answer question 5a below.
☐ **Yes** ☐ **No**	Lung Disease (Emphysema, Chronic Obstructive Pulmonary Disease (COPD), etc.) – *If Yes:* ☐ **Yes** ☐ **No** Are you on oxygen? *If No*, answer question 5a below.

5a. Please tell us about your condition(s):

☐ **Yes** ☐ **No** 6. Are you currently taking any prescription medications? If yes, please complete the following. If additional medications, please attach a separate sheet.

Medication	Reason for taking	Dosage

Section 7: Tobacco Use

☐ **Yes** ☐ **No**	Have you used tobacco, in any form, in the last 12 months?

Section 8: Terms and Conditions

Your insurance is being offered through Medical Mutual of Ohio© and/or one of it's subsidiaries, Medical Health Insuring Corporation of Ohio©, collectively referred to as "Medical Mutual".

While I am a Medical Mutual subscriber, I hereby authorize the Medicare Part A and Part B carriers in Ohio to provide Medical Mutual with a copy of my Explanation of Medicare Benefits (EOMB) statements resulting from the payment of Medicare Part A and Part B claims.

I authorize: release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, prescription history database supplier, government agency or person to Medical Mutual and/or any affiliates or division of Medical Mutual: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize Medical Mutual to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this application.

I understand and agree that no agent or broker has the authority: (1) to bind Medical Mutual by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this Application or any information Medical Mutual requests; (3) approve coverage; (4) make or alter any contract on behalf of Medical Mutual; or (5) waive or alter any of Medical Mutual other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.

I understand and agree that any information obtained will not be released by Medical Mutual to any person or organization except to reinsuring companies, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. Once personal and health information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to Medical Mutual's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by Medical Mutual's Privacy Office.

I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

I have read this entire Application and declare all information, statements, and answers to be true and complete. I understand that my coverage can be cancelled or rescinded by Medical Mutual if I have misstated or omitted any information.

I understand that I must be a resident of and live in the State of Ohio at least six (6) months of each year, to be eligible for this policy.

continued on next page

Section 8: Terms and Conditions (cont.)

If the underwriting company is Medical Mutual of Ohio, I hereby appoint as my proxy, to act for and on my behalf at any and every annual meeting and special meeting of the members of Medical Mutual of Ohio, the person who is Secretary of such corporation at the time of such annual or special meetings, as the case may be, with power of substitution, and hereby empower such proxy to vote and act for and on my behalf at each such meeting as fully and to the same extent as I could do if personally present thereat. This proxy shall continue in force for ten (10) years from the date hereof unless sooner revoked by a writing signed by me and delivered to Medical Mutual of Ohio.

WARNING: 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. (Ohio Revised Code Section 3999.21)

Print Name	Signature	Date

For Internal Use Only

Agent of Record	Tax ID

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Multi-Language Interpreter Services & Nondiscrimination Notice

MEDICAL MUTUAL®

This document notifies individuals of how to seek assistance if they speak a language other than English.

Spanish

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-382-5729 (TTY: 711).

Chinese

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 1-800-382-5729 (TTY: 711)。

German

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-382-5729 (TTY: 711).

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-382-5729 رقم هاتف الصم والبكم 711).

Pennsylvania Dutch

Wann du Deitsch schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-800-382-5729 (TTY: 711).

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-382-5729 (телетайп: 711).

French

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-382-5729 (ATS: 711).

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-382-5729 (TTY: 711).

Navajo

Díí baa akó nínízin: Díí saad bee yáníłti' go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-382-5729 (TTY: 711).

Oromo

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-382-5729 (TTY: 711).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-382-5729 (TTY: 711)번으로 전화해 주십시오.

Italian

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-382-5729 (TTY: 711).

Japanese

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。1-800-382-5729 (TTY: 711) まで、お電話にてご連絡ください。

Dutch

AANDACHT: Als u nederlands spreekt, kunt u gratis gebruikmaken van de taalkundige diensten. Bel 1-800-382-5729 (TTY: 711).

Ukrainian

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-382-5729 (телетайп: 711).

Romanian

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-382-5729 (TTY: 711).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-382-5729 (TTY: 711).

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Order Number: Z8188-MCA R11/16
Dept of Ins. Filing Number: Z8188-MCA R9/16

QUESTIONS ABOUT YOUR BENEFITS OR OTHER INQUIRIES ABOUT YOUR HEALTH INSURANCE SHOULD BE DIRECTED TO MEDICAL MUTUAL'S CUSTOMER CARE DEPARTMENT AT 1-800-382-5729.

Nondiscrimination Notice

Medical Mutual of Ohio complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex in its operation of health programs and activities. Medical Mutual does not exclude people or treat them differently because of race, color, national origin, age, disability or sex in its operation of health programs and activities.

- Medical Mutual provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, etc.).
- Medical Mutual provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services or if you believe Medical Mutual failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, with respect to your health care benefits or services, you can submit a written complaint to the person listed below. Please include as much detail as possible in your written complaint to allow us to effectively research and respond.

Civil Rights Coordinator
Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44115-1355
MZ: 01-10-1900

Email: CivilRightsCoordinator@MedMutual.com

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:
  ocrportal.hhs.gov/ocr/portal/lobby.jsf
- By mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW Room 509F
  HHH Building
  Washington, DC 20201-0004
- By phone at:
  (800) 368-1019 (TDD: (800) 537-7697)
- Complaint forms are available at:
  hhs.gov/ocr/office/file/index.html

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MEDICAL MUTUAL®

2060 East Ninth Street
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Z7079-MCS R7/18