WMI® Mutual Insurance™ Company
PO Box 572450, Salt Lake City, Utah 84157-2450
(801) 263-8000

Medicare Supplement Application

Part I – Personal Information

Last Name _____ First Name _____ MI _____

Home Address _____
(must be the same as the residency for income tax purposes) City State Zip

Billing Address _____
(if different from home address) City State Zip

Email: _____

Date of Birth _____ ☐ Male ☐ Female

Home Phone: _____ Cell Phone: _____

Social Security #: _____ Medicare ID Number: _____

Select a Plan: Plan A ☐ Plan C* ☐ Plan F* ☐ Plan G ☐ Plan N ☐

*These plans are not available for individuals who: (a) have attained age 65 on or after January 1, 2020; or (b) first become eligible for Medicare due to age, disability or end-stage renal disease on or after January 1, 2020. These plans are also not available in Montana.

Requested Effective Date: _____

Part II - General Information

(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

(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. Upon receipt of timely notice, the issuer must return to you

that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, subject to adjustment for paid claims. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for 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 a policy to supplement Medicare by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your policy to supplement Medicare can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your policy to supplement Medicare under these circumstances, and later lose your employer or union-based group health plan, your suspended policy to supplement Medicare 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 policy to supplement Medicare 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.

(6) 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 Specified Low-Income Medicare Beneficiary ("SLMB").

Part III – Open Enrollment Eligibility

Federal law allows a six-month open enrollment period beginning with the first day of the first month in which an applicant is both: (1) age 65 or older; and (2) enrolled in Medicare part B. If you are a qualified open enrollee, you may apply for and receive any Medicare Supplement plan available from us.

(1) Did you turn age 65 in the last six months? ☐ Yes ☐ No

(2) Did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No

If yes, what is your Part B effective date (mm/dd/yyyy)? _____

(3) **If you are applying for a Medigap policy in Utah and you have guaranteed issue rights, you do not have to answer this question.** Have you used tobacco in any form in the past year?
☐ Yes ☐ No What Type? Please provide details below:

Part IV – Guarantee Issue Eligibility

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 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. You must apply within 63 days of the date of termination of previous coverage in order to qualify for guarantee issue.

If one of the following situations apply to you, check the appropriate box and include a copy of the notice from your prior insurer with your application. **Check one only.**

☐ Enrolled under an employer welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits.

☐ 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.

☐ 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 policy provision, or a material misrepresentation was made to the individual.

☐ Enrolled in a Medicare Supplement policy and coverage is being discontinued due to insolvency, substantial violation of a material policy provision, or material misrepresentation.

☐ Enrolled under a Medicare Supplement policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan or a PACE provider, and then terminates coverage within 12 months of enrollment.

☐ Upon first becoming eligible for benefits under Part A at age 65, enrolls in a Medicare Advantage or PACE provider and then disenrolls within 12 months.

☐ Enrolled in a Medicare Part D plan during the initial Part D enrollment period while enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and terminate the Medicare Supplement policy.

☐ Enrolled under medical assistance under Title XIX of the Social Security Act (Medicaid), and your Medicaid coverage is involuntarily terminated.

Part V – Past and Current Coverage Information

Please answer all questions below, to the best of your knowledge, by marking Yes or No with an "X".

(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.) ☐ Yes ☐ No If yes:

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

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

(2) 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 _____

(a) 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

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

(c) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐Yes ☐No

(3) Do you have any other Medicare supplement policy in force? ☐ Yes ☐ No

(a) If so, with what company, and what plan do you have? Please provide details below:

(b) If so, do you intend to replace your current Medicare supplement policy with this policy?
☐ Yes ☐ No

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

(a) If so, with what company, and what kind of policy? Please provide details below:

(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.)

Part VI – Medical Questions

For applicants who are applying during initial Open Enrollment or who are eligible for guarantee issue, this section does not need to be completed. For all other applicants, complete this section by answering all questions below, and provide additional information where applicable (use additional sheets, if necessary). If you do not meet underwriting guidelines, you may not be issued a policy.

SECTION A:

1. **Do any of these apply to you? Please check all that apply.**

   ☐ End-stage renal (kidney) disease*
   ☐ Currently receiving dialysis*
   ☐ Diagnosed with kidney disease that may require dialysis*
   ☐ Admitted to hospital as inpatient within the past ninety (90) days*
   ☐ Been diagnosed or treated for AIDS or AIDS-related conditions or tested positive for the presence of HIV antibodies, antigens, or the virus*
   ☐ None of the above apply to me

   *Please provide details below:

2. **Within the past five (5) years, has a medical professional recommended or discussed as a treatment option any of the following that has <u>not</u> been completed?** ☐ Yes ☐ No

   ☐ Hospital admission as an inpatient*
   ☐ Heart surgery*
   ☐ Vascular surgery*
   ☐ Surgery, radiation, or chemotherapy for cancer*
   ☐ Back or spine surgery*
   ☐ Joint replacement*
   ☐ Organ transplant*
   ☐ None of these apply to me

   *Please provide details below:

SECTION B:

Have you had, been diagnosed with, or been treated for, any of the following in the past five (5) years?

- ☐ Cancer or leukemia (except basal cell skin cancer)*
- ☐ Systemic lupus erythematosus ("SLE"), rheumatoid arthritis*
- ☐ Alzheimer's disease or dementia*
- ☐ Complications of diabetes including kidney disorder, neuropathy, retinopathy*
- ☐ Angina pectoris, heart attack, coronary artery disease, congestive heart failure, stroke, mini-stroke, transient ischemic attack ("TIA"), peripheral vascular disease, abnormal heart rhythm (including pacemaker implantation), carotid artery disease*
- ☐ Organ or bone marrow transplant*
- ☐ Parkinson's disease, amyotrophic lateral sclerosis ("ALS" or "Lou Gehrig's disease"), multiple sclerosis ("MS"), paraplegia, quadriplegia, or hemiplegia*
- ☐ Chronic kidney or liver disease*
- ☐ None of these apply to me

*Please provide details below:

SECTION C:

Enter your Height: _____ feet _____ inches Enter your Weight: _____ pounds

1. Have you suffered any falls or other accidental injuries in the past three (3) years?
   ☐ Yes ☐ No
   If yes, please provide details below:

2. Do you have any of the following chronic health conditions?

☐ arthritis*	☐ asthma*	☐ clotting disorder*
☐ depression*	☐ diabetes*	☐ hyperlipidemia*
☐ hypertension*	☐ osteoporosis*	☐ other (specify below)
☐ oxygen use*	☐ physical therapy*	☐ none of the above

*Please provide details below:

3. When was your last doctor visit: _____
   Please list any symptoms you were having, the test results, the diagnosis and the treatment:

4. Please list any medical tests, treatment, therapy or care that has been recommended but not yet performed. Please provide details below:

5. Have you ever been treated for, or had treatment recommended for, excessive alcohol or drug use? ☐ Yes ☐ No

6. Have you ever used illegal drugs? ☐ Yes ☐ No
7. Have you been in a hospital, been confined to a nursing home or an assisted living facility, or received home health care in the past ninety (90) days? ☐ Yes ☐ No
8. If the answer to question #7 is "no," has confinement been advised? ☐ Yes ☐ No
   Provide details for any answers marked "yes" for questions 4-7. Please provide details below:

SECTION D: LIST ANY PRESCRIPTION MEDICATION OR TREATMENT TAKEN OR PRESCRIBED OVER THE PAST TWO (2) YEARS (use additional sheet if necessary):

Prescription Name	**Dosage**	**Reason for Taking the Medication**	**Date Last Taken MM/YY**

Provide the name and address of any pharmacy where you have obtained a prescription drug or medication during the past two (2) years. Please provide details below:

Part VII – Agreement and Acknowledgement

I hereby request coverage for the Medicare Supplement Plan marked above. I have read and fully understand the questions and my answers on this application. To the best of my knowledge and belief, they are true and accurate. I understand that the services and benefits set forth in my contract with WMI will be available only on or after the effective date as shall be determined by the enrollment regulations of WMI.

I further understand and agree that all medical and hospital records pertaining to my health, including diagnosis, treatment, or services provided to myself by any doctor, hospital, health care provider, or pharmacy, shall be made available and I hereby authorize their release, upon request, to WMI and its underwriters, in order to determine whether a policy can be issued to me. I also authorize release to WMI all information contained in Medicare Title XVIII claims, billings, and service reports submitted by me or in my behalf. This authorization shall be valid for a period of thirty (30) months from the date it is signed.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

Applicant's Name (Print)	Telephone Number
Applicant's Signature (Type Name if Signing Electronically)	Date Signed

Electronic Signature - Consent and Authorization: This application may be submitted electronically or in hard copy form. In order for this application to be submitted electronically, it must be signed electronically and the applicant must authorize and consent to the use of electronic documents and signatures. The electronic signature and submission of this application has the same validity as a handwritten application and signature.

Electronic Signature:

Please Type Your First and Last Name

☐ **I hereby agree that the electronic signature affixed hereto is a valid and legal signature, and I acknowledge the truthfulness and accuracy of the information provided herein.**

The applicant, or a person authorized to act on the applicant's behalf, is entitled to receive a copy of this authorization at any time.

Part VIII – Premium Payment

Select how you would like to pay for your Medicare Supplement premiums from one of the options below if a Medicare supplement policy is issued to you. Billing periods are on a monthly basis. Annual age adjustments will automatically be applied as of the month that follows your birthday. Please do not send payment with this application.

☐ Direct Bill

☐ Automatic Bank Account Withdrawal (Account type: ☐ Checking ☐ Savings)

If automatic bank account withdrawal is chosen, please complete the following information:

Bank Name: _____

Bank Account Name(s) (exactly as it appears on the account) _____

Bank Routing # (9 digits): _____

Bank Account #: _____

For Producer Use Only

Please list any other health insurance policies you have sold to the applicant in the last five years, including those that are no longer in force.

Name of Insurance Company	Type of Policy	Policy Number	Effective Date	In Force
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no
				☐ yes ☐ no

Please answer all of the following questions.

1) Did you meet with the applicant in person? ☐ yes ☐ no
2) Did you review the application for correctness and any omissions? ☐ yes ☐ no
3) Did the applicant review the application for correctness and any omissions? ☐ yes ☐ no

Producer Name _____ Producer License Number _____

Producer Signature _____ Date _____