Group Health Cooperative
of South Central Wisconsin

a non-profit consumer-sponsored health plan

Administrative Offices
1265 John Q. Hammons Dr.
P.O. Box 44971
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(608) 251-4156
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ghcscw.com

Part 1: MEDICARE SELECT APPLICATION

Section I – PERSONAL INFORMATION (Please print)

NAME Last	First	Middle Initial		Date of Birth *(MM/DD/YY)*
ADDRESS Street	City	State	Zip Code	Social Security Number
Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed		Phone Number		Gender (M/F)
Are you enrolled in Federal Medicare? Part A – Hospital ☐ Yes ☐ No Part B – Medical ☐ Yes ☐ No		Medicare Identification Number _____ Effective Date _____ Effective Date _____		
Primary Care Practitioner				

Section II – INFORMATION ABOUT OTHER COVERAGE (Please answer all questions)

If you lost or are losing other health coverage and received a notice from your prior insurance company saying that you were eligible for guaranteed issue of a Medicare supplement or Medicare select insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in our Medicare Select plan. Please include a copy of the notice from your prior insurance company with your application.

To the best of your knowledge:

1. a. Did you turn 65 in the last 6 months? ..... Yes ☐ No ☐
   b. Did you enroll in Medicare Part B in the last 6 months? ..... Yes ☐ No ☐
   c. If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program? ..... Yes ☐ No ☐
   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 ☐
3. 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 health maintenance organization or a preferred provider organization), fill in your start and end dates below.

   START____/____/____ END____/____/____ (If you are still covered under this plan, leave "END" blank)

   b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this GHC-SCW Medicare Select policy? ..... Yes ☐ No ☐
   c. Was this your first time in this type of Medicare plan? ..... Yes ☐ No ☐
   d. Did you drop a Medicare supplement or select policy to enroll in the Medicare plan? ..... Yes ☐ No ☐

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Section II – Continued

4. a. Do you have another Medicare Supplement or Medicare Select policy in force?.....Yes☐ No☐
   b. If yes, with what company and what plan do you have? _____
   c. If yes, do you intend to replace your current policy with this GHC-SCW Medicare Select Policy?.....Yes☐ No☐
5. Have you had coverage under any other health insurance within the past 63 days?.....Yes☐ No☐
   (For example, an employer, union, or individual plan)
   a. If yes, 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 this plan, leave "END" blank.)

Section III – AUTHORIZATION

Please read carefully the information below. If you do not understand these provisions for coverage under this Medicare Select Policy, ask the GHC-SCW representative for further explanation.

I authorize GHC-SCW or any other holder of medical or other information about me to release to the Center for Medicare and Medicaid Services or intermediaries or carriers any information needed to administer Title XVIII of the Social Security Act.

I authorize any practitioner, hospital or other provider of health services to disclose to GHC-SCW any information concerning health services provided to me. I agree this authorization shall be valid for two and one-half (2½) year from the signature date below.

I understand that medical care will be covered by GHC-SCW only if it is:

1. provided by Group Health Cooperative of South Central Wisconsin
2. provided with prior authorization of a GHC-SCW practitioner
3. provided for emergency care or urgent care out-of-area, as further described in the Medicare Select Subscriber Policy

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SIGNATURE OF APPLICANT for Part 1: Medicare Select Application DATE

Part 2: MEDICARE SELECT APPLICATION ACKNOWLEDGEMENT

1. You do not need more than one Medicare supplement, Medicare cost or Medicare Select policy.
2. If you purchase this policy, you may want to evaluate any other existing health care coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement, Medicare cost or Medicare Select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under

your Medicare Select policy can be suspended, if requested, for a total of 24 months during your entitlement to benefits under Medicaid. You must request this suspension within 90 days of becoming eligible for Medicaid.

If you are no longer entitled to Medicaid, your suspended policy may be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Select policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated 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 Medicare Select 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 Select policy can be suspended, if requested, while you are covered by the employer or union-based group health plan. If you suspend your Medicare Select policy for this reason and later lose your employer or union-based health plan, your suspended Medicare Select policy, or if that is no longer available, a substantially equivalent policy will be reinstated effective as of the date you lost coverage under the group health plan. To reinstate your Medicare Select policy you must:

- Provide notice of loss of coverage under the group health plan within 90 days of the date you lost coverage and;
- Pay the premium for the period effective as of the date of loss of coverage.

If the Medicare Select policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated 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 are available to provide advice concerning your purchase of a Medicare Select 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). See the booklet *Wisconsin Guide to Health Insurance for People with Medicare* with you received at the time you were solicited to purchase this policy.

7. Guarantee issue – Medicare Select issuers must guarantee issue basic Medicare Select policies to eligible individuals. This means that GHC-SCW cannot discriminate in the pricing of such a policy because of health status, claims experience, receipt of health care, medical condition or age, and cannot impose a pre-existing condition exclusion. To determine if you are eligible for guarantee issue of this plan, please complete the questions in Section II.

Please sign below to acknowledge that you have read and understand the above statements.

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SIGNATURE OF APPLICANT for Part 2: Medicare Select Application Acknowledgement DATE

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Part 3: NOTICE TO APPLICANTS

NOTICE TO APPLICANT: REGARDING REPLACEMENT OF MEDICARE SUPPLIMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

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

According to your application, you intend to terminate existing Medicare supplement, Medicare cost, Medicare select or Medicare Advantage insurance and replace it with a Medicare Select policy to be issued by Group Health Cooperative of South Central Wisconsin (GHC-SCW). Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Select coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select coverage or leave your Medicare Advantage plan. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy. Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE

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

☐ Additional benefits

☐ No change in benefits, but lower premium

☐ Fewer benefits and lower premiums

☐ My plan has prescription drug coverage and I am enrolling in Medicare Part D

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

_____

_____

☐ Other (please specify)_____

_____

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1. Note: If the issuer of the Medicare Select policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement 2 below. Health conditions that you may presently have (pre-existing 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 condition waiting periods. The insurer will waive any time periods applicable to pre-existing conditions waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history, if any. Failure to include all requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all requested information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure you want to keep it.

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SIGNATURE OF APPLICANT for Part 3: Notice to Applicant DATE

_____

Signature of Agent, Broker or Other Representative DATE
(Signature not required for direct response sales)

_____

Printed name of Address of Issuer, Agent or Broker
(Not required for direct response sales)

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Part 4: ACKNOWLEDGEMENT OF RECEIPT

Acknowledgement of Receipt

Outline of Coverage, OCI Brochure, and Notice of Medicare Select Policy Restrictions

The undersigned hereby acknowledges that he/she has given and received a copy of the documents listed as follows:

1. **Outline of Coverage** to permit comparison with your current coverage, This outline includes a description of:

   - Hospital Services covered under this Policy
   - Medicare Part B services covered under this Policy
   - Summary of Benefits provided by GHC-SCW
   - Summary of Limitations and Exclusions
   - Coverage by non-GHC-SCW practitioners
   - In-area emergency and urgent care
   - Out-of-area emergency and urgent care
   - Quality Assurance Program
   - Claims Appeal/Grievance procedure

2. "Wisconsin Guide to Health Insurance for People with Medicare" brochure published by the Wisconsin Office of the Commissioner if Insurance (OCI).

I understand that this GHC-SCW Medicare Select Policy has restrictions as to the practitioners that may be used for non-emergency care (see provider directory enclosed). To continue as a subscriber under this Medicare Select Policy, I understand that I must be eligible for and covered by Medicare Parts A and B, and live within GHC-SCW's service area.

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SIGNATURE OF APPLICANT for Part 4: Acknowledgement of Receipt DATE

FOR OFFICE USE ONLY:	Group Number: 6565_____	Effective Date:_____