Group Health Cooperative
of South Central Wisconsin

Administrative Offices
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MEDICARE SELECT ENROLLMENT APPLICATION

Section 1 - Applicant Information

Name: Last First M.I.

Date of Birth (MM/DD/YY): | Legal Sex: ☐ M ☐ F

Social Security Number: _____ - _____ - _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Street Address: | Apt./Unit #:

City: | State: | Zip:

Phone Number: | Email:

Section 2 - Primary Care Physician

Primary Care Physician: | Clinic Name:

Clinic Address:

Section 3 - Medicare Information

Please provide the following information as it appears on your Medicare ID Card:

Name

_____

Medicare Number

_____ - _____ - _____

Entitled to	Coverage Starts
HOSPITAL (PART A)	_____ - _____ - _____
MEDICAL (PART B)	_____ - _____ - _____

Section 4 - Information About Other Coverage

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 one of our Medicare Select plans. Please include a copy of the notice from your prior insurance company with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark Yes or No below with an "X."

1. Did you turn 65 in the last 6 months? ☐ Yes ☐ No
   a. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
   b. If yes, what is the effective date? ___ /___ /_____

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 this question.
   If you answered "Yes" to this question:
   a. Will Medicaid pay your premiums for this Medicare select policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No

3. 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.)
   a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new GHC-SCW Medicare select policy? ☐ Yes ☐ No
   b. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   c. Did you drop a Medicare supplement or select policy to enroll in the Medicare policy? ☐ Yes ☐ No

4. Do you have another Medicare supplement or Medicare select policy in force? ☐ Yes ☐ No
   a. If yes, with what company, and what plan do you have? _____
   b. If yes, do you intend to replace your current Medicare supplement or Medicare select 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 5 - Plan Selection

GHC-SCW offers two Medicare select policies: *Medicare Select Plan* and *Medicare Select Healthy You* .

If you FIRST became ELIGIBLE for Medicare ON or AFTER January 1, 2020, you are ONLY eligible for GHC-SCW's *Medicare Select Healthy You* policy.

Please choose the ONE policy you are applying for:

☐ *Medicare Select Plan*

☐ *Medicare Select Healthy You*

Section 6 – Health Questionnaire

Do NOT complete this section if you are applying for coverage during:

- **Your Medicare Supplement Open Enrollment Period**
  - You are in your Medicare Supplement Open Enrollment Period if you are applying within six (6) months of enrolling in Medicare Part B or within six (6) months of the month you turn 65 and you were already enrolled in Medicare before turning 65
- **Under Guaranteed Issue**
  - 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 or Medicare select policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance to this policy. Please include a copy of the notice from your prior insurer with your application.
  - You may find a full list of qualifying guaranteed-issue scenarios in the Wisconsin Office of the Commissioner's brochure titled, "Wisconsin Guide to the Health Insurance for People with Medicare."

If you should NOT complete this section, continue to Section 7.

Please answer the following questions. If you answer "yes" to any of the following questions, you are NOT eligible for a GHC-SCW Medicare select policy at this time.

1. Do any of the following statements **currently** describe you? ☐Yes ☐No
   - I am confined to a nursing facility.
   - I am hospitalized.
   - I am enrolled in a hospice program.

2. Have you been diagnosed with one or more of the following **at any time**? ☐Yes ☐No
   - AIDS*
   - Alzheimer's Disease
   - Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)
   - Cerebral Palsy
   - Cystic Fibrosis
   - Emphysema
   - Hemophilia
   - Multiple Sclerosis
   - Muscular Dystrophy
   - Myasthenia Gravis
   - Parkinson's Disease
   - Rheumatoid Arthritis
   - Sickle Cell Anemia
   - Systemic Lupus

   * The reporting of HIV test results is limited to only the results of FDA licensed tests. HIV test results received at an anonymous counseling and testing site do not need to be reported.

3. Have any of the following applied to you within the past **five years**? ☐ Yes ☐ No

- You have had or received treatment or surgery for cancer (except for non-melanoma skin cancer), Hodgkin's Disease, Melanoma, or Leukemia.
- You have had, or have been recommended to have, any organ transplant other than of the cornea.

4. Have any of the following applied to you within the past **two years**? ☐ Yes ☐ No

- You have been hospitalized (more than 24 hours) three times or more, or have been recommended to have inpatient surgery that hasn't yet been performed.
- You have been hospitalized for alcohol or drug abuse.
- You have had or been told by your physician you had a heart attack, congestive heart failure, heart valve disorder, heart rhythm disorder, enlarged heart, coronary artery disease (hardening or narrowing of the artery or arterial blockage), carotid artery disease, stroke, aneurysm, or peripheral vascular disease.
- You have had or been told by your physician you had diabetes that requires insulin, liver disease, or broken bones due to osteoporosis.
- You have had or received treatment for End Stage Renal Disease (ESRD) kidney disease, or have received kidney dialysis.

STOP: If you answered "yes" to any of the questions in this section, you are not eligible for a GHC-SCW Medicare select policy at this time. If you need assistance answering these questions, please contact us or speak with your agent.

If you answered "no" to ALL of the questions in this section, please proceed to Section 7.

Section 7 – Consent to Release Medical Information and Applicant Agreement

Please carefully read the information below. If you do not understand the provisions contact GHC-SCW.

By signing this application below, I understand and agree that I am applying for a Group Health Cooperative of South Central Wisconsin (GHC-SCW) Medicare select policy and that:

1. All statements and answers I've given are complete and true to the best of my knowledge and belief. I understand that any material misstatement in this application may result in denial of claims and/or rescission of coverage.
2. The policy I herby apply for will be effective only when GHC-SCW approves this application. Evidence of such approval will be issuance of the policy.
3. I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record of knowledge of me to give GHC-SCW or its legal representative, reinsurers, authorized agents or designees, any and all information (excluding psychotherapy notes) in any form about me concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether I have obtained a test for the presence of HIV, antigen or nonantigenic products of HIV, or an antibody of HIV or the results of such a test, if obtained by me. The information obtained by this consent will be used by GHC-SCW to determine eligibility for coverage under this policy, and understand that my failure to consent to the release of this information may result in GHC-SCW's refusal to issue or provide coverage.
   I understand that this authorization is revocable, except to the extent that action has been taken in reliance upon it, and that this authorization will remain in force for thirty (30) months in order to effectuate the purposes for which it is given. I understand that to revoke this authorization I must provide advance written notice of termination to GHC-SCW.
4. I understand that an insurance agent or broker cannot modify or waive the terms, conditions, or provisions of the insurance policy, application or requirement imposed by GHC-SCW, nor bind coverage or guarantee approval or coverage. I further understand that GHC-SCW, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorneys' fees), I may suffer as a result of any improper advice, action, or omission on the part of any insurance agent or broker.
5. I understand and acknowledge it is a crime for any person who has the intent to defraud or is knowingly facilitating fraud against GHC-SCW to submit an application or file a claim containing a false and deceptive statement.
6. I hereby acknowledge I received a copy of the Outline of Coverage for the GHC-SCW Medicare select policy I am applying for and a copy of the brochure titled, "Wisconsin Guide to Health Insurance for People with Medicare" before applying for this policy.
7. I understand that I should retain a copy of this completed application for my own records, and that a photographic copy shall be as valid as the original statement.

I have considered all factors written above, and I believe this policy suits my needs. I authorize GHC-SCW or other holder of medical or related information to release to the Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any information necessary to administer Title XVIII of the Social Security Act.

_____ _____

(Applicant's Signature) **(Date)**

Section 8 – Important Statements

PLEASE SAVE A COPY OF THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

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 your 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 or Medicare select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement, Medicare cost or Medicare select 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, Medicare cost or Medicare select 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, Medicare cost or Medicare select 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.
5. If you are eligible for and have enrolled in a Medicare supplement or Medicare cost 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 or Medicare cost 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 or Medicare cost policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement or Medicare cost 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 or Medicare cost 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.
6. Counseling services may be available in your state or provide advice concerning your purchase of Medicare supplement or Medicare cost 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). See the booklet “Wisconsin Guide to Health Insurance for People with Medicare" which you received at the time you were solicited to purchase this policy.

Section 9 – Notice to Applicant Regarding Replacement of Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident and Sickness Insurance

PLEASE SAVE A COPY OF THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

1. 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 GHC-SCW. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.
2. 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, or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Section 10 – 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, if applicable, 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 premiums.
- ☐ 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).

_____

_____

_____

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. 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. If your policy is guaranteed issue (not health underwritten), this paragraph does not apply.

_____ _____

(Agent, Broker, or Other Representative Signature) (Date)

_____ _____

(Applicant's Signature) **(Date)**

Section 11 – Statement to GHC-SCW by Agent

1. Have you sold any policy to the applicant that is still in force? ☐ Yes ☐ No

   a. If yes, please list: _____

2. Have you sold any policy to the applicant in the past five years which is no longer in force? ☐ Yes ☐ No

   a. If yes, please list: _____

I certify this information is true.

_____ _____

(Agent's Signature) (Date)

Section 12 – Acknowledgement of Receipt

I acknowledge that I received and understand the following information from GHC-SCW:

- Outline of Coverage for the policy I am applying for
- Wisconsin Guide to Health Insurance for People with Medicare," published by the Wisconsin Office of the Commissioner or Insurance
- "Important Statements" in Section 8 of this application
- "Notice to Applicant Regarding Replacement of Medicare Supplement, Medicare Cost, Medicare Select, Medicare Advantage or Existing Accident and Sickness Insurance" in Section 9 of this application

_____ _____

(Agent, Broker, or Other Representative Signature) (Date)

_____ _____

(Applicant's Signature) **(Date)**