Medigap Application

EMI HEALTH

5101 South Commerce Drive
Murray, Utah 84107
801-262-7475

EMI Health Medigap Application

Plans underwritten or operated by Educators Health Plans, Life, Accident, and Health

Please select one - this application request is for:

☐ **Open Enrollment**
If you are applying for coverage to start within the six-month period immediately following your enrollment in Medicare Part B and you are 65 or older, this is your Open Enrollment period. During this period, you cannot be denied a Medigap policy or be charged more due to past or present health problems.

☐ **Guaranteed Issue**
If you have lost, or are losing, other health insurance coverage you may apply for Guaranteed Issue. You will be required to provide proof that you have lost coverage within the last 63 days. If you qualify for Guaranteed Issue, you cannot be denied a Medigap policy or be charged more due to past or present health problems.

☐ **Other Enrollment**
If you do not fall under Open Enrollment or Guaranteed Issue, your application is subject to medical underwriting to determine whether it will be approved and, if so, at what rate.

APPLICANT INFORMATION

Full Name (First, M.I., Last) _____

Street Address _____

City _____ County _____

State _____ Zip Code _____ Phone Number (____) _____

Birth Date (mm/dd/yyyy) ____ / ____ / ____ Age _____ Gender (M / F) _____

Email Address _____

Social Security Number ____ - ____ - ____

Medicare Claim Number _____

Medicare Part A effective date (mm/dd/yyyy) ____ / 01 / ____

Medicare Part B effective date (mm/dd/yyyy) ____ / 01 / ____

PLAN SELECTION - Choose one of the following Medigap Plans.

(The monthly premium rate can be found in the Outline of Coverage. Medigap policies are effective on the first of the month after approval.)

☐ Plan F ☐ Plan G

Requested Medigap start date (mm/dd/yyyy) _____ / 01 / _____

HOUSEHOLD DISCOUNT

A household discount may be available if two or more members reside at the same address. (The household discount only applies to Medigap policies, and is not retroactive.)

Are you requesting the Household Premium Discount? ☐ Yes ☐ No

a) If Yes, please provide the following information for the other person:

Name (First, M.I., Last) _____

DOB (mm/dd/yyyy) _____ / _____ / _____ SSN _____ — _____ — _____

Address _____

Upon verification of eligibility, both Medigap policies will qualify for the Household Premium Discount of 5% per policy (effective the 1st of the month following the date the discount is approved).

PAYMENT OPTIONS - Please select a payment option.

☐ Receive a monthly bill (direct billing)

☐ Electronic Funds Transfer (EFT) directly from your account each month. Please provide the following information and include/attach a VOIDED check.

Account Type ☐ Checking ☐ Savings

Account Holder _____ Signature _____

Routing # _____ Account # _____

By signing above, I hereby authorize EMI Health to withdraw my total monthly premium payment on or about the first day of each month, for the following month's premium, as indicated above. The authority is to remain in effect until EMI Health has received written notification from me at least 30 days prior to the next scheduled payment, or until I receive written notification of termination from EMI Health. Failed withdrawls will be subject to an additional administrative fee.

PRODUCER INFORMATION - To be completed by Producer when applicable.

I, (the producer), certify that I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions, or limitations of the contract except through written materials furnished by EMI Health. I have informed the applicant that the effective date of coverage is assigned only by EMI Health.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

Producer Name _____ EMI Health Producer # _____

Producer Signature _____ Date (mm/dd/yyyy) _____ / _____ / _____

PAST AND CURRENT COVERAGE

Medicaid Information

Are you covered for medical assistance through the state Medicaid program? (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

a) Will Medicaid pay your premiums for this Medigap policy? ☐ Yes ☐ No

b) Do you receive any benefits from Medicaid other than payments towards your Medicare Part B premium? ☐ Yes ☐ No

Trial Period Information

Have 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)? ☐ Yes ☐ No

If Yes: Start ____/____/____ End ____/____/____

a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medigap policy? ☐ Yes ☐ No

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

c) Did you voluntarily disenroll from a Medigap policy to enroll in the Medicare plan? ☐ Yes ☐ No

Replacement and Other Coverage Information

Do you have another Medigap policy in force? ☐ Yes ☐ No

a) If Yes, with which company and what plan do you have?

_____

b) If Yes, do you intend to replace your current Medigap policy with this contract? ☐ Yes ☐ No

Have you had coverage under any other health insurance within the past 63 days? ☐ Yes ☐ No

a) If Yes, with which company and what kind of policy

_____

b) If Yes, what are your dates of coverage under the other policy? (If you are still covered under this plan, leave "End" blank.)

Start ____/____/____ End ____/____/____

c) If Yes, do you intend to replace your current policy with this contact? ☐ Yes ☐ No

HEALTH QUESTIONNAIRE

If you are applying during your Open Enrollment or you qualify for the Guaranteed Issue, you may skip the Health Questionnaire. If you fall under Other Enollment, please complete the Health Questionnaire.

Do you currently have kidney failure requiring dialysis? ☐ Yes ☐ No

Have you been admitted to a hospital as an inpatient within the last 90 days? ☐ Yes ☐ No

If you answered YES to either of these questions, you are NOT eligible for these plans at this time.

Within the last three years, have you had a diagnosis, treatment, or advice relating to any of the following:

	Y	N
1. Accident, injury, or deformity	☐	☐
2. Acquired Immune Deficiency Syndrome (AIDS) or related disease	☐	☐
3. Alcohol or drug dependency	☐	☐
4. Anemia, blood disease, or Leukemia	☐	☐
5. Arthritis or Rheumatoid Arthritis	☐	☐
6. Asthma or chronic bronchitis	☐	☐
7. Back trouble (recurrent/chronic)	☐	☐
8. Cancer or tumor	☐	☐
9. Dementia or Alzheimer's	☐	☐
10. Diabetes	☐	☐
11. Dizziness or headaches (frequent)	☐	☐
12. Epilepsy or convulsions	☐	☐
13. Ear, nose, or throat disorders	☐	☐
14. Eye disorder, glaucoma	☐	☐
15. Female disorders, fibroids, or excessive or irregular bleeding	☐	☐
16. Gallbladder	☐	☐
17. Heart or circulatory	☐	☐
18. High or low blood pressure or cholesterol	☐	☐
19. Intestines, bowel or colon	☐	☐
20. Joint problems, including knee and other	☐	☐
21. Kidney or bladder	☐	☐
22. Liver disorder or hepatitis	☐	☐
23. Lung problems, chronic obstructive pulmonary disease, emphysema or oxygen use	☐	☐
24. Mental anxiety, emotional condition, or depression	☐	☐
25. Muscular Disorders, Dystrophies	☐	☐
26. Neurological disease or Parkinson's	☐	☐
27. Neuritis, chronic or recurrent numbness/tingling	☐	☐
28. Obesity (overweight)	☐	☐
29. Prostate disorder	☐	☐
30. Rectal disorder, hemorrhoids, or bleeding	☐	☐
31. Sciatica or chronic pain	☐	☐
32. Skin condition or disease, melanoma	☐	☐
33. Stroke	☐	☐
34. Stomach disorders, frequent or chronic heartburn	☐	☐
35. Thyroid or glandular	☐	☐
36. Ulcer (stomach or duodenal)	☐	☐
37. Varicose veins, phlebitis, or blood clots	☐	☐

HEALTH QUESTIONNAIRE (continued)

Height (feet and inches) _____ Weight (pounds) _____

Have you used any form of tobacco in the past 12 months? ☐ Yes ☐ No

A. Please explain below any items that you checked "Yes" on the previous page.

Question #	Year	Duration	Disease or Condition	Recovery complete?

B. Have you been advised to have an operation that was not performed? ☐ Yes ☐ No

If Yes, please give full details, including name and address of physician

_____

_____

C. Have you been hospitalized in the last 5 years or are you currently hospitalized or in an extended care facility? ☐ Yes ☐ No

If Yes, please explain below:

Hospitalization Date	Disease, Injury, or Condition	Name of Operation

D. Are you planning to be hospitalized within the next 6 months? ☐ Yes ☐ No

If Yes, please explain _____

_____

E. Have you taken any prescription medications within the past 12 months? ☐ Yes ☐ No

If **Yes,** please explain below:

Medication	Medical Condition	Still taking?

SIGNATURE PAGE

Please Read the Following Statements Before Signing This Application

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 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 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 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 assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I certify the above statements to be complete and true, to the best of my knowledge. I understand that this contract will become effective when accepted by EMI Health. I hereby authorize a licensed physician, medical practitioner, hospital, clinic, or other medical or medically-related facility, insurance company, or other organization, or person, who has any records or knowledge of me or my health, to provide EMI Health any such information. A photographic copy of this authorization / acknowledgment will be valid as the original.

Applicant Signature _____ Date of Application ___/___/___

Legal Authorized Representative Name _____ Relationship _____

Legal Authorized Representative Signature _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT (Medigap) INSURANCE OR MEDICARE ADVANTAGE

According to your application (information you have furnished), you intend to terminate the existing Medicare Supplement or Medicare Advantage and replace it with a policy to be issued by EMI Health. 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 new 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 (Medigap) coverage is a wise decision, you should terminate your present Medicare Supplement (Medigap) or Medicare Advantage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

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

- ☐ Additional benefits
- ☐ No change in benefits, but lower rates
- ☐ Fewer benefits and lower rates
- ☐ 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) _____

Health conditions which 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.

State law provides that your replacement policy or certificate may not contain new preexisting 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.

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 material medical information on an application may provide a basis for the company to deny any future claims and to refund your rates 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 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.

_____ _____

*Producer's Signature Applicant's Signature

_____ _____

EMI Health Producer Number Date

_____

Date

**Producer signature not required if you do not have a Producer*

Policy Disclosures

Read your policy very carefully
This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and EMI Health.

Right to return policy
If you find that you are not satisfied with your policy, you may return it to EMI Health, 5101 South Commerce Drive, Murray, Utah 84107. If you send the policy back within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy replacement
If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

Premiums
EMI Health can only raise your premium if we raise the premium for all policies like yours in Utah.

Notice
This policy may not fully cover all of your medical costs. EMI Health is not connected with Medicare. This outline of coverage does not give all details of Medicare coverage. We recommend consulting the publication Medicare and You for more details.