

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE
For Seniors with Medicare Parts A and B



SECTION 1 – CHOICE OF COVERAGE

Please check the box for your choice of coverage:

- STANDARD PLAN A STANDARD PLAN C STANDARD PLAN G STANDARD PLAN N

SECTION 2 – APPLICATION INFORMATION

A copy of this application will be returned to you, for your records, along with your policy, when you are enrolled.

Please copy the information from your Medicare card here



NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
_____	_____	_____
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE (PART A)	_____	
MEDICAL INSURANCE (PART B)	_____	

Requested effective date, or end date of prior Medicare supplement, if replacing ____ / ____ / ____

Name (as it appears on your Medicare card) _____

Social Security Number

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 Date of Birth _____

Home Address, Apt. No., Suite No. _____

City _____ County _____ State _____ Zip _____

E-mail Address: _____

Home Telephone Number _____

Billing Address, (if different from home address) _____

City _____ County _____ State _____ Zip _____

Care of/Attention _____

SECTION 3 – BILLING INFORMATION

- Annual Semi-Annual Quarterly Monthly

PAC (Checking Account Deduction Only)

Please indicate a preferred draft date (excluding the 29th, 30th, 31st) _____

Affix check here. Please make check or money order for premium payable to Philadelphia American Life Insurance Company.

No agency checks are accepted.

Applicant: Please return application to agent or to the address below:

Philadelphia American Life Insurance Company, Underwriting Department
P.O. Box 4884
Houston, Texas 77210-4884

SECTION 4 – HEALTH HISTORY

THIS SECTION MUST BE COMPLETED BY APPLICANT

IF APPLYING DURING THE OPEN ENROLLMENT PERIOD OR IF YOU ARE A GUARANTEED ISSUED ELIGIBLE PERSON, DO NOT COMPLETE THIS SECTION (Skip to Section 5)

If the answer to any of the following questions is “Yes”, you are not eligible for coverage. Check the box next to any conditions that apply to you.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair, cane or walker for any daily activity? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 2 years, have you been advised to have surgery which has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past 5 years, have you ever consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions: | | |
| a. Heart or vascular conditions including but not limited to heart attack, open heart surgery, placement of a stent, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, peripheral vascular disease, coronary artery disease, irregular heartbeat or stroke? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer’s disease, Parkinson’s disease, senile dementia, organic brain disorder, any neurological disorder or other senility disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, emphysema or use of inhalers, nebulizers or oxygen? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internal cancer, leukemia, melanoma, Hodgkin’s disease, insulin dependent diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea) or amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. In the past 12 months have you had placement of a pacemaker or had a joint replacement? | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant’s Initials: _____

SECTION 5 – MEDICAL INFORMATION

Name of Primary Care Physician _____ Telephone (____) _____

Address _____

SECTION 6 – GENERAL INFORMATION

ANSWER ALL QUESTIONS IN THIS SECTION TO THE BEST OF YOUR KNOWLEDGE

Did you turn age 65 in the last 6 months? Yes No

Do you meet the definition of an Eligible Person as defined in this application? Yes No

Did you enroll in Medicare Part B in the last 6 months? Yes No

If yes, what is the effective date? _____

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.} Yes No

If yes; will Medicaid pay your premiums for this Medicare supplement policy? Yes No

If yes; do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

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 ___ / ___ / ___

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

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

Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No

Do you have another Medicare supplement policy in force? Yes No

If so, with what company, and what plan do you have? _____

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

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

If so, with what company and what kind of policy? _____

If so, what are your dates of coverage under the other policy? START ___ / ___ / ___ END ___ / ___ / ___ (If you are still covered under the other policy, leave "END" blank.)

TOBACCO USAGE

Have you used any form of tobacco within the past 5 years? Yes No

I acknowledge that misrepresentation of this information may render the policy null and void.

Date: _____

Applicant's Signature

SECTION 7 – CONDITIONS OF APPLICATION

Please read the following carefully.

1. I agree to submit the premium required for the plan requested with this application. Such premium will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. Philadelphia American will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B or when I am an Eligible Person for Guaranteed Issue. If my application is not received during the open enrollment period, Philadelphia American has the right to reject my application. If Philadelphia American rejects my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that if Philadelphia American rejects my application, under no circumstances will any Philadelphia American benefits be payable. **Cashing of my check by Philadelphia American does not constitute approval of my application.**
3. If my application is accepted, this application will become part of the agreement between Philadelphia American and myself.
4. The selling agent has no authority to promise me coverage or to modify Philadelphia American underwriting policy or terms of any Philadelphia American coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that Philadelphia American may void all coverage from the original effective date of the policy for intentional material misstatements or omissions.

SECTION 8 – AUTHORIZATION AND AGREEMENTS

Notice to Applicant

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 coverages.
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. 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 reinstated 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 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 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the 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 a Specified Low-Income Medicare Beneficiary (SLMB).

Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization for Your Files If Requested. (Read all five paragraphs and sign below)

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Philadelphia American any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize Philadelphia American, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Philadelphia American to process claims. A photocopy shall be valid.
- I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), the Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare," and "Outline of Medicare Supplement Coverage and Premium Information" as required. I understand that receipt of money with this application does not create Philadelphia American coverage. Coverage will come into effect only if this application is approved by Philadelphia American.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or intentional material misrepresentation in the Application may result in loss of coverage under the policy.

Warning: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits

X

Applicant's Signature

Date of Signature

MEDICARE SUPPLEMENT PLAN REPLACEMENT WORKSHEET

Agents please complete if replacing other existing Medicare coverage

Insured

Name	SS#
Proposed Plan	

Old Plan

Company Name	
Expiration Date	Contract No.

Benefit Comparison

See reverse side for Philadelphia American benefits. Check benefits that apply.

**Philadelphia
American
Plan**

Write in benefits not listed.

	Old Plan	
Part A Deductible		
Part A Coinsurance		
Additional Hospital Days		
Skilled Nursing Facility Coinsurance		
Hospice		
Part B Deductible		
20% Part B Coinsurance		
50% Part B Coinsurance (Nervous and Mental)		
Part B Excess Charges at 100%		
Prescription Drugs		
Emergency Travel Benefits Outside the U.S.		
At-Home Recovery (pre June 1, 2010 Standardized plans)		
Preventive Medical Care (pre June 1, 2010 Standardized plans)		
10% or Greater Premium Savings		

Does this plan have benefits clearly and substantially better than those of the old plans? _____ If yes, explain below: Agent Signature _____ Agent No. _____ Date _____
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OPTIONAL MONTHLY CHECKING ACCOUNT DEDUCTION AUTHORIZATION FOR SENIORS

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of Philadelphia American Life Insurance Company provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Philadelphia American to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Philadelphia American premiums. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no obligation whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Insured _____ X Date	Social Security Number _____ Bank Name _____ X Date
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Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

PRIORITY PROCESSING

COMPLETE THIS FORM TO ENROLL IN THE
OPTIONAL MONTHLY CHECKING ACCOUNT
DEDUCTION
AUTHORIZATION FOR SENIORS.

INCLUDE A BLANK CHECK MARKED "VOID".

A DEPOSIT SLIP IS NOT ACCEPTABLE.

**PHILADELPHIA AMERICAN LIFE
INSURANCE COMPANY**

**SENIOR SERVICES
TOLL-FREE NUMBER**



Monday – Friday
8:00 a.m. to 5:00 p.m.

(877) 368-4691

FOR AGENT ONLY

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr. _____	_____	Name: _____
To: Mo./Yr. _____	_____	Address: _____
	_____	City/State: _____

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage and a disclosure statement for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

SIGNED AT

Agent's Signature _____ Date of Signature _____ (City and State) _____

Print Agent's Name _____ Agent No. _____

Street Address _____ Telephone No. _____

City _____ State _____ ZIP _____

E-mail Address: _____ *For split commissions, please add name and agent no.*

Premium Amount \$ _____ Agent Name _____

Send Policy To: Agent Insured Agent No. _____

SENIOR SERVICES TOLL-FREE NUMBER

Monday - Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)

(877) 368-4691

PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY

PREMIUM RECEIPT

Date _____ Amount _____

Name _____

Social Security Number _____

Account _____ Check Number _____

Policy Description _____

Received by _____

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.

ELIGIBLE PERSONS FOR GUARANTEED ISSUE

ELIGIBLE PERSON means an individual who:

Is enrolled under an employee 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 to the individual; or the individual is or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or ceases to provide all health benefits to the individual because the individual leaves the plan.

Is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in Medicare Advantage plan:

- (a) The certification of the organization or plan has been terminated; or
- (b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;
- (c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the federal Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;
- (d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:
 - (i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or
 - (ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or
- (e) The individual meets such other exceptional conditions as the Secretary may provide.

Is enrolled with an entity listed in subparagraphs (i) -- (iv) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Section 12B(2).

- (i) An eligible organization under a contract under Section 1876 of the Social Security Act (Medicare cost);
- (ii) A similar organization operating under demonstration project authority, effective for periods before April 1, 1999;
- (iii) An organization under an agreement under Section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
- (iv) An organization under a Medicare Select policy.

Is enrolled under a Medicare Supplement policy and the enrollment ceases because:

- (a) Of the insolvency of the issuer or bankruptcy of the non-issuer organization;
- (b) Of other involuntary termination of coverage or enrollment under the policy; or
- (c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Is enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or Medicare Select policy; and the subsequent enrollment is terminated by the enrollee during any period within the first 12 months of such subsequent enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

Upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in Medicare Advantage plan under Part C of Medicare, or in a PACE program under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

Is enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare part D along with the application for a Medicare Supplement plan of A, B, C, F (including F with high deductible), K or L that is offered and is available for issuance to new enrollees by the same issuer that issued the individual's Medicare supplement policy with outpatient prescription drug coverage.



P.O. Box 4884
Houston, Texas 77210-4884