Providence Health Assurance

2024

Group Medicare Supplement (Medigap) Application Form

Personal information

EMPLOYER GROUP NAME

EMPLOYER GROUP NUMBER

FIRST NAME

LAST NAME

MI

DATE OF BIRTH

WHAT IS YOUR STATUS WITH THIS GROUP:

☐ ACTIVELY EMPLOYED ☐ RETIRED EMPLOYEE ☐ SPOUSE OF AN ACTIVE OR RETIRED EMPLOYEE

PERMANENT RESIDENCE STREET ADDRESS

COUNTY

MAILING ADDRESS (IF DIFFERENT FROM STREET ADDRESS)

GENDER: ☐ Male ☐ Female

( ) -

CELL PHONE

( ) -

HOME PHONE
(IF OTHER THAN CELL PHONE)

EMAIL ADDRESS (REQUIRED)

By providing your email address, you are agreeing to receive important account information and product offers. Be sure to write all necessary symbols, such as (.) and (@) in the space above.

Please answer the following questions so we can determine if you are eligible for a premium discount.

	YES	NO
In the past 12 months, at any time, have you used cigarettes, cigars, pipe tobacco, chew or snuff?	☐	☐

Household discount

A household discount of up to 20% off your monthly premium may be available if you (1) are married or live with a domestic partner and reside at the same physical address, or (2) have resided with at least one, but no more than three other adults in the last 12 months at the same physical address. The household discount is not available to those living in a one-person household, or in an assisted living facility.

FIRST NAME

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MI

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RELATIONSHIP

Providence may validate householder eligibility and may request additional documentation. If you are deemed ineligible for the household discount after the effective date of your coverage, your premium will be adjusted back to your original effective date.

Medicare information

Please supply the information below from your Medicare card:

NAME _____ MEDICARE NUMBER _____

HOSPITAL (PART A) EFFECTIVE DATE ____/____/____

MEDICAL (PART B) EFFECTIVE DATE ____/____/____

	YES	NO
Are both Medicare Parts A & B coverage active (or will be active by the plan effective date)?	☐	☐

Indicate your Medicare Supplement plan

Which plan do you want to purchase (check one)? ☐ A ☐ G ☐ N

Requested Effective Date: please indicate the date (MONTH / DAY / YEAR): ____/____/____

Eligibility

You are eligible for these Group Medicare Supplement plans if you are age 65 or older, are enrolled in Medicare Parts A & B, and are not duplicating Medicare supplement coverage from another plan (for example, Medicare Advantage). You must also reside in our service area for this Supplement coverage.

Please review the following information about Medicare Supplement policies

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 coverage.

You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

If you suspend your Medicare supplement policy under these circumstances, later 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.

NOTE: 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 insurance 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. Please include a copy of the notice from your prior insurer with your Application Form.

Authorization and verification of application information

I declare the answers on this Application Form are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that this Application Form becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, Providence Health Assurance may have the right to rescind my coverage, adjust my premium or reduce my benefits.

Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.

I understand coverage, if provided, will not take effect until issued by Providence Health Assurance, the actual premium is not determined until coverage is issued and that this Application Form and payment of the initial premium does not guarantee coverage will be provided.

I acknowledge receipt of the currently available Outline of Coverage and the document "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" published by the Centers for Medicare & Medicaid Services.

I understand that I must be enrolled in Medicare Part A and Part B to be eligible for Medigap coverage and if Medicare Part A and/or Part B terminate for any reason, my Medigap policy will automatically terminate.

Authorization for use and release of protected health information

I understand that the following parties may need to collect information on me in regard to the proposed coverage: Providence Health Assurance and its reinsurers, any insurance support organization, any consumer reporting agency and all persons authorized to represent these organizations for this purpose.

Any and all individually identifiable health information, including but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results may be disclosed to or by Providence Health Assurance to the extent permitted by applicable federal and state laws. This medical or health information may include information on the diagnosis and treatment of mental illness, and alcohol and drug use to the extent permitted by applicable federal and state laws. This also includes information on the diagnosis, treatment and testing results related to HIV, AIDS and sexually transmitted diseases, unless otherwise restricted by applicable federal and/or state law.

Those parties who may need to collect information may disclose information to the following: Other insurers to whom I've applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearinghouses; or persons who perform business, professional or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 12 months after the date signed.

I understand I can revoke this authorization any time by contacting Providence Customer Service.* I also understand that my revocation won't affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation. To revoke this authorization, please send a written statement to Providence Health Assurance at Providence Medicare Supplement Enrollment Department, PO Box 14590, Salem, OR 97309 and state that you are revoking this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but if I don't, I may not be eligible for enrollment. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

APPLICANT OR PERSONAL REPRESENTATIVE'S SIGNATURE

DATE OF APPLICANT OR PERSONAL REPRESENTATIVE'S SIGNATURE

APPLICANT'S NAME (PLEASE PRINT)

TO BE COMPLETED BY AGENT/BROKER ONLY

AGENT NAME (PLEASE PRINT)

FIRST NAME | LAST NAME | MI

AGENT SIGNATURE (REQUIRED) | AGENT ID (REQUIRED) | TODAY'S DATE (REQUIRED)

AGENT EMAIL ADDRESS | AGENT PHONE NUMBER