



Medicare Supplement Enrollment Form

- ☐ (AA) - New Application
 ☐ (S) - Cancellation Date __/__/____
 ☐ (SR) - Subscriber Request
☐ (AC) - Request Change
 ☐ (SD) - Subscriber Deceased

Employer Group Applicants Only		Group Name:		Group Number:	
Coverage Selection (check one type of coverage)					Requested Month For Coverage to Begin (coverage starts 1st of the month):
☐ Medicare Supplement A ☐ Medicare Supplement B ☐ Medicare Supplement C* ☐ Medicare Supplement D ☐ Medicare Supplement F* ☐ Medicare Supplement F+* ☐ Medicare Supplement G ☐ Medicare Supplement G+ ☐ Medicare Supplement N					
* Available only to applicants first eligible for Medicare before January 1, 2020.					
General Information (one person per application)					
Name (Last Name, First Name, Middle Initial) ☐ Check if name change			Date of Birth 		☐ Male ☐ Female
Day Phone 		Medicare ID Number 		Part A Effective Date 	Part B Effective Date
Mailing/Billing Address (street) ☐ Check if address change			City, State, Zip		County
Permanent Residence Street Address (if different from mailing address - PO box not allowed) City, State, Zip					
Email Address (optional)					
Choose Your Method of Payment					
If you don't select a payment option, you will get a bill each month. Please select a premium payment option:					
Billing Cycle (Select One): ☐ Monthly ☐ Quarterly ☐ Annually					
☐ Get a bill.					
☐ Electronic Funds Transfer (EFT) from your bank account. Please enclose a VOIDED check or provide the following:					
Account Holder Name:					
Bank Routing Number:			Bank Account Number:		
Account Type: ☐ Checking ☐ Savings					

NOTICE TO APPLICANT: The sale of a Medicare supplement policy is prohibited where an individual has a Medicare supplement policy in force and does not desire to replace the existing policy, or where the Medicare supplement policy would duplicate benefits to which the individual is entitled under a Medicare Advantage plan.

Statements

- You do not need more than one Medicare supplement policy or certificate.
- If you purchase this policy (certificate), 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 (certificate).
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy (certificate) may 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 (certificate) (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 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 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 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 the suspension.
- 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).

Questions To the best of your knowledge and belief: Please mark Yes or No below with an "X"

1. Did you turn age 65 in the last 6 months?	☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months? If yes, what is the effective date? _____	☐ Yes ☐ No
3. Are you covered for medical assistance through the state Medicaid program? (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 YES, answer both questions below.	☐ Yes ☐ No
• Will Medicaid pay your premiums for this Medicare supplement policy?	☐ Yes ☐ No
• Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes ☐ No
4. If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates to the right. If you are still covered under the Medicare Advantage plan, leave END DATE blank.	Start Date / / End Date / /
• If you are still covered under the Medicare Advantage 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 Advantage plan?	☐ Yes ☐ No
• Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan?	☐ Yes ☐ No

If you have any questions, please call: 1-800-659-1986

Questions To the best of your knowledge and belief: Please mark Yes or No below with an "X"5. Do you have another Medicare supplement or Medicare Select policy or certificate 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 or Medicare Select policy or certificate with this policy or certificate? ☐ Yes ☐ No6. Have you had coverage under any other health insurance policy or certificate 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? _____

• What are your dates of coverage under the other policy?
(If you are still covered under the other policy, leave END DATE blank)

Start Date / /

End Date / /

Note: A break in coverage of more than 63 days could result in enforcing waiting period for pre-existing conditions. Our Medicare supplement plans are subject to a six (6)-month waiting period for pre-existing conditions unless prior coverage affords credit for some or all of this time period.

I HAVE READ AND I UNDERSTAND THE QUESTIONS AND STATEMENTS ABOVE. ALL INFORMATION FURNISHED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

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, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED \$5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Applicant's Signature _____ Date: ____/____/____

Sales Agent/Broker Name _____ NPN# _____ Agent ID # _____

To be completed by Agent: "I have reviewed the current health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs." _____

Univera Healthcare Use Only

Group number

Package number

Effective Date (mm/dd/yy)

If you have any questions, please call: 1-800-659-1986

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex (consistent with the scope of sex discrimination as described at 45CFR section 92.10(a)(2)). The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, gender identity, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, gender identity, or sex; you can file a grievance with the Health Plan's Section 1557 Coordinator at:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Email: Advocacy.Department@UniveraHealthcare.com
Telephone number: 1-800-614-6575
TTY number: 1-800-662-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

This notice is available at Univera Healthcare's website: www.Univerahealthcare.com

ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. To access these services, please call us at 1-877-626-9298 (TTY: 1-800-662-1220).
ATENCIÓN: Si habla español, tiene disponible servicios gratuitos de asistencia lingüística. También hay disponible de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Para acceder a estos servicios, llámenos al 1-877-626-9298 (TTY: 1-800-662-1220).
انتباه: إذا كنت تتحدث العربية فإن خدمات مساعدة اللغة المجانية مُناحة لك. تتوفر أيضًا المساعدات والخدمات المساعدة المناسبة لتوفير المعلومات بتنسيقات يسهل الوصول إليها مجانًا. للوصول إلى هذه الخدمات، يُرجى الاتصال بنا على الرقم 1-877-626-9298 (الهاتف النصي: 1-800-662-1220).
注意：如果您說中文，我們可以為您提供免費的語言幫助。我們也可以為您免費提供適當的輔助工具和服務，以無障礙格式提供資訊。要獲得這些服務，請撥打 1-877-626-9298（TTY：1-800-662-1220）。
ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et des services supplémentaires appropriés pour fournir des informations dans des formats accessibles sont aussi disponibles gratuitement. Pour accéder à ces services, veuillez nous appeler au 1 877 626 9298 (TTY [ATS] : 1 800 662 1220).
দৃষ্টি আকর্ষণ: আপনি যদি বাংলাতে কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফরম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সাহায্য এবং পরিষেবাগুলি ও বিনামূল্যে উপলব্ধ। এই পরিষেবাগুলি অ্যাক্সেস করার জন্য, অনুগ্রহ করে আমাদের 1-877-626-9298 (TTY: 1-800-662-1220) নম্বরে কল করুন।
ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги языковой поддержки. Также бесплатно доступны соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах. Чтобы воспользоваться этими услугами, позвоните нам по номеру 1-877-626-9298 (TTY: 1-800-662-1220).
ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने, निःशुल्क भाषा सहायता सेवाहरू तपाईंका लागि उपलब्ध छन्। सुलभ ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि निःशुल्क उपलब्ध छन्। यी सेवाहरू उपयाेग गर्न, कृपया हामीलाई 1-877-626-9298 (TTY: 1-800-662-1220) मा फोन गर्नुहोस्।
УВАГА: Якщо Ви говорите українською, Вам доступні безкоштовні послуги мовної підтримки. Відповідні допоміжні засоби та послуги для надання інформації в доступних форматах також надаються безкоштовно. Щоб скористатися цими послугами, зателефонуйте нам за номером: 1-877-626-9298 (TTY [Телетайп]: 1-800-662-1220).

FIIRO-GAAR AH: Haddii aad ku hadashid Soomaali, adeeggyada caawimaada luuqadda oo bilaashka ah ayaad helayso. Agabka caawimaada naafada iyo adeeggyo ku habboon oo lagu bixinaayo macluumaadka qaabab la helo karo ayaa sidoo kale lagu heli karaa bilaa lacag. Si loo helo adeegyadaan, fadlan naga soo wac 1-877-626-9298 (TTY: 1-800-662-1220).
ဟ်သုဉ်ဟ်သး- နမ့ၣ်ကတိၤအဲကလံးကျိၣ်န့ၣ်, တၢ်တိၤစၢၤမၤစၢၤကျိၣ် တၢ်မၤစၢၤတၢ်မၤ အကလီအိၣ်လၢနဂီၢ် လၢနမၤန့ၢ်အီၤသ့လီၤ. တၢ်မၤစၢၤတၢ်န့ၢ်ဟ့ၣ်ပိးလီၤ ဒီး တၢ်မၤစၢၤတၢ်မၤ လၢအဘၣ်ဘျိးဘၣ်ဒါတဖၣ် ကဟ့ၣ်လီၤ တၢ်ဂ့ၢ်တၢ်ကျိၤ လၢကျိၤကျဲလၢတၢ်န့ၢ်လီၤမၤန့ၢ်အီၤသ့တဖၣ် စ့ၢ်ကိး အိၣ်လၢနမၤန့ၢ်အီၤသ့ လၢတလိၣ်ဟ့ၣ်အပူၤဘၣ်န့ၢ်လီၤ. လၢကမၤန့ၢ်တၢ်မၤစၢၤတၢ်မၤတဖၣ်အံၤအဂီၢ်, ဝံသးစူၤ ကိးပုၤဖဲ 1-877-626-9298 (TTY: 1-800-662-1220).
သတိပြုရန်- သင် မြန်မာ ပြောဆိုလျှင် ဘာသာစကားအကူအညီ ဝန်ဆောင်မှုများကို သင့်အတွက် အခမဲ့ရရှိနိုင်သည်။ မသန်စွမ်းသူများ အသုံးပြုနိုင်သည့် ဖောမတ်များဖြင့် အချက်အလက်များ ပံ့ပိုးပေးနိုင်သည့် သင့်လျော်သော ထောက်ပံ့ပစ္စည်းများနှင့် ဝန်ဆောင်မှုများကိုလည်း အခမဲ့ရရှိနိုင်ပါသည်။ ဤဝန်ဆောင်မှုများကို ရရှိရန် ကျွန်ုပ်တို့ကို 1-877-626-9298 (TTY- 1-800-662-1220) သို့ ဖုန်းခေါ်ဆိုပါ။
CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Các dịch vụ và hỗ trợ bổ sung thích hợp để cung cấp thông tin ở các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Để sử dụng các dịch vụ này, vui lòng gọi cho chúng tôi theo số 1-877-626-9298 (TTY: 1-800-662-1220).
ATANSYON: Si ou pale Kreyòl Ayisyen, sèvis asistans lang gratis disponib pou ou. Èd ak sèvis oksilyè apwopriye pou bay enfòmasyon nan fòm aksesib yo disponib tou gratis. Pou jwenn aksè nan sèvis sa yo, tanpri rele nou nan 1-877-626-9298 (TTY: 1-800-662-1220).
توجه: اگر به زبان دری صحبت می کنید، خدمات کمک زبان رایگان برای شما قابل دسترس است. کمک امدادی مناسب و خدمات برای دسترسی به معلومات در فرمت میسر بصورت مجانی ارائه می شود. برای دسترسی به این خدمات، با این شماره ها تماس حاصل کنید 1-877-626-9298 (TTY: 1-800-662-1220).
TAHADHARI: Ikiwa unazungumza Kiswahili, huduma za usaidizi wa lugha bila malipo zinapatikana kwa ajili yako. Misaada ya ziada inayofaa na huduma za kutoa habari katika miundo inayofikika zinapatikana pia bila malipo Ili kupata huduma hizi, tafadhali tupigie simu kwa 1-877-626-9298 (TTY: 1-800-662-1220).