

STATEMENTS

- You do not need more than one Medicare Supplement/Medicare Select policy or certificate. If you purchase this policy, you may want to evaluate any other existing health care coverage and decide if you want multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement/Medicare Select policy or certificate. The benefits and premiums under this Medicare Select contract can be suspended, if requested, for a total of 24 months during your entitlement to benefits under Medicaid. You must request this suspension in writing within 90 days of becoming eligible for Medicaid. If you become no longer entitled to Medicaid, this contract may be reinstated if requested in writing within 90 days of losing Medicaid eligibility and your Medicare Select policy has not been suspended for more than 24 months.
- Insurance counseling services are available in your state to provide advice concerning Medical Assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs), and Specified Low Income Medicare Beneficiaries (SLMBs).

AGREEMENT & CERTIFICATION

Your signature on the front of this application verifies that you have received a copy of the “Guide to Health Insurance for People with Medicare,” a “Sanford Health Plan Medicare Supplement Outline of Coverage,” and if this is a replacement policy, you have received a copy of the “Replacement Notice.”

Your signature also verifies you have read the preceding statements and answers and declare them to be true and complete and you agree to the conditions of enrollment and apply for enrollment with Sanford Health Plan. Furthermore, you understand and agree that coverage, if approved, will commence in accordance with Section I of your application.

For administrative convenience, Sanford Health Plan may deposit in a bank any cash or check you submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage. If this application is rejected, a refund check will be mailed to you.

Complete answers are very important: Your signature verifies that you understand and agree that we will act reliance upon the information you have provided herein. When you fill out this application, be sure to answer truthfully and completely all questions about your medical health history. Sanford Health Plan may cancel your policy and refuse to pay any claims if you falsify important medical information. NOTE: If this policy is guaranteed issue, this statement does not apply.

Review this application carefully before you sign it. Be certain that all information has been properly recorded.

MEDICARE SUPPLEMENT PLAN

APPLICATION FOR COVERAGE



HEALTHCARE BUILT FOR YOU



PO Box 91110
Sioux Falls, SD 57109-1110
(605) 328-6800
1-800-752-5863

New Enrollee Open Enrollment
 Change of Coverage
 Is this application for reinstatement of a policy which lapsed due to nonpayment of premium? Yes No
 Is this application for reinstatement of a policy which was suspended due to entitlement of Medicaid benefits? Yes No
 Please add my name to the Discoveries Mailing List

MEDICARE SUPPLEMENT PLAN APPLICATION FOR COVERAGE

SECTION I: APPLICANT INFORMATION

Name _____ Birth Date ____/____/____
Last First MI

Address _____
Street & Apt. # City County State Zip

Phone (____) _____ Social Security Number _____ Gender Male Female

How did you hear about us? Newspaper Agent Direct Mail Other _____

Tobacco Use Designation and Declaration: I have used tobacco and/or smokeless tobacco during the 36 months immediately preceding the date of this application. Yes No

SD & IA Plan Options	MN Plan Options	Available w/riders
<input type="checkbox"/> Standard Plan A <input type="checkbox"/> SELECT Plan A	<input type="checkbox"/> Extended Basic Supplement	<input type="checkbox"/> Basic Supplement
<input type="checkbox"/> Standard Plan C <input type="checkbox"/> SELECT Plan C	<input type="checkbox"/> Extended Basic SELECT	<input type="checkbox"/> Part A Deductible Rider
<input type="checkbox"/> Standard Plan F <input type="checkbox"/> SELECT Plan F	<input type="checkbox"/> Basic SELECT	<input type="checkbox"/> Part B Deductible Rider
<input type="checkbox"/> Standard Plan F (high deductible)		<input type="checkbox"/> 100% Part B Excess Rider

Requested Effective Date: ____/____/____ If approved, coverage will be effective upon underwriting approval (if applicable). Applications are only good for 60 days beyond the date signed, except for applicants in their open enrollment period (applications are good for 6 months).

SECTION II: ELIGIBILITY QUESTIONS

- Are you enrolled for coverage under Part A (Hospital) and Part B (Medical) of Medicare?
 Yes No (If No, you are not eligible for this coverage). Medicare Number (As shown on your Medicare Card): _____
 Medicare Part A (Hospital) Effective Date: ____/____/____ Medicare Part B (Medical) Effective Date: ____/____/____
- Do you have any other health insurance policies that provide benefits that this Medicare Supplement contract would duplicate? Yes No
 (a) Is it a Medicare Supplement/Medicare SELECT Policy? Yes No
 (b) If you answered yes, what is your expected termination date or paid through date? _____
 (c) If you answered yes to the above questions list:

Company Name Type of Policy Policy #

- Are you covered for Medical Assistance through the state Medicaid program? Yes No. If YES, which of the following programs provides coverage for you? Qualified Medicare Beneficiary (QMB); Specified Low-Income Medicare Beneficiary (SLMB); or Full Medicaid Beneficiary
- Were you or are you enrolled in a Medicare Select, Medicare Supplement, Medicare Advantage, Employer Retiree Plan, Medicare Cost or Health Care PrePayment Plan and the Plan is terminating your coverage? Yes No

Termination Date of Current Coverage: ____/____/____ You must include a copy of your current plan's termination letter. NOTE: Under state laws, you may be eligible for a guarantee issue of coverage. You must apply within 63 calendar days of the termination date listed above in order for us to determine if guarantee issue of coverage applies to you.

SECTION III: HEALTH QUESTIONS

You do not need to complete this section if you are applying for coverage within six-months of obtaining Medicare Part B (your open enrollment period); or if you answered YES to questions #4 above and qualify for Guarantee Issue. Check "YES" or "NO" and circle all diagnoses that apply.

- Do you have Parkinson's Disease or Multiple or Lateral Sclerosis? Yes No
- Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer (excluding skin cancer), alcoholism or drug abuse; cirrhosis; mental or nervous disorder requiring psychiatric care; or have you had any amputation caused by disease? Yes No
- Within the past two years have you been treated for or been advised by a physician to have treatment for heart, coronary or carotid artery disease; high blood pressure; peripheral vascular disease; congestive heart failure or enlarged heart; stroke; transient ischemic attacks (TIA); or heart rhythm disorders? Yes No
- Within the past two years have you been treated for osteoporosis, degenerative bone disease, or crippling arthritis? Yes No
- Have you been advised to have surgery or medical tests that have not been performed? Yes No
- Have you been hospital confined three or more times in the last two years? Yes No
- Have you been rejected for nursing home care or long term care insurance? Yes No
- Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? Yes No
- Do you have emphysema, Chronic Obstructive Pulmonary Disease (COPD), other Chronic Pulmonary disorders or use oxygen at home (excluding oxygen use for Sleep Apnea)? Yes No
- Have you been diagnosed with Alzheimer's Disease, senile dementia, organic brain disorder, or any other senility disorder? Yes No
- Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No
- Do you have kidney disease requiring dialysis or diabetes with Hemoglobin A1C greater than 8.3? Yes No
- Please list your medication(s) in the box below:

Drug Name	Dosage/Frequency	Reason for medication	Cost per month

SECTION IV: APPLICANT AUTHORIZATION

Applicant Signature X _____ Date ____/____/____

- Payment Method (check one)
 Monthly Automatic Account Withdrawal
 Quarterly Payment by Check

ALL AGENTS MUST COMPLETE AND SIGN:

Application was completed by applicant agent.
 I certify that I have reviewed this application. If application was completed by agent, agent certifies that he/she personally completed this application, that each question was asked separately, that the answers recorded in this application are complete and accurate as given.

() Attach list if other policies sold to this applicant in the past 5 years (indicate if they are still in force.)

Agent's Signature ID# Phone Number Date

For Internal Use Only:

Date Entered: _____

Initials: _____

Effective Date: _____