MEDICAL MUTUAL OF OHIO®
MEDICARE SUPPLEMENT
ENROLLMENT APPLICATION

MMO USE ONLY
Effective Date: / /
Group No.

SECTION I: IMPORTANT MANDATED INFORMATION

- 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.
- The benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility.
- 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).

SECTION II: CONTRACT HOLDER INFORMATION

Last Name	MI	First Name		SS Number	Sex
Address		Email Address		Phone Number	
City	County	State	Zip	Birth date / /	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed				Smoker: ☐ Yes ☐ No	

SECTION III: MEDICARE ELIGIBILITY

In order to be eligible for a Medical Mutual Medicare Supplement Policy, you must be 65 years or older and be enrolled in Medicare Part A (hospital insurance) and Medicare Part B (medical insurance). The following information can be found on your Medicare Card:

Effective date of Medicare Part A (hospital insurance)	/ /
Effective date of Medicare Part B (medical insurance)	/ /
Medicare Number	

SECTION IV: EFFECTIVE DATE

The effective date for your Medicare Supplement Plan is the first of the month following Medical Mutual's receipt of the completed application. If a later date is requested, indicate below:

What month should coverage start?	/ 01 / 200__

SECTION V: PRODUCTS

Select one plan option: ☐ Plan A ☐ Plan C ☐ Plan F ☐ Medicare Select Plan C(1)

In which region do you permanently reside?(2) ☐ Region 1 ☐ Region 2

(1) Medicare Select is only offered in Fulton, Henry, Lucas, Ottawa, Sandusky and Wood Counties.
(2) Please refer to the Monthly Premium Information Sheet for your region.

SECTION VI: OTHER COVERAGE INFORMATION

1. ☐ Yes ☐ No Are you or your spouse currently employed? If yes, complete below:

Employer	Employer's Address

2. ☐ Yes ☐ No Does your employer or spouse's employer provide any type of group health insurance?

If yes, explain why you and your spouse are not covered under the employer's group insurance policy?

3. ☐ Yes ☐ No Are you covered for medical assistance through the state Medicaid program?
4. ☐ Yes ☐ No Are you covered as a Specified Low-Income Medicare Beneficiary (SLMB)?
5. ☐ Yes ☐ No Are you covered as a Qualified Medicare Beneficiary (QMB)?
6. ☐ Yes ☐ No Are you covered for other Medicaid medical benefits?
7. ☐ Yes ☐ No Do you have another Medicare supplement insurance policy or certificate in force (including health care service contract or Health Maintenance Organization (HMO) contract)?

If yes, with which company:

8. ☐ Yes ☐ No Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?

If yes, with which company:

9. ☐ Yes ☐ No If the answer is yes to questions No. 1 through No. 8, do you intend to replace your current healthcare coverage with this policy? If yes, please complete a Replacement Coverage Form and have your broker or agent fill out question No. 10.

TO BE COMPLETED BY INSURANCE AGENT OR BROKER

10. ☐ Yes ☐ No Does the applicant have any other health insurance policies that I, as the agent or broker, have sold to the applicant? If yes, list the policies sold which are still in force and/or list the policies sold in the past five (5) years which are no longer in force.

Name of Plan	Type of Coverage	Start Date of Coverage	End Date of Coverage

Broker or Agent Signature	Date

You do not have to complete Section VII: Medical Eligibility if this application is being submitted within six (6) months from the month in which you first enrolled for benefits under Medicare Part B.

SECTION VII: MEDICAL ELIGIBILITY

1. ☐ Yes ☐ No Have you been hospitalized two (2) or more times within the past 12 months? If yes, please complete the following:

Detail of Condition, Injury or Ailment	Start and End Dates	Physician

2. ☐ Yes ☐ No Are you currently confined to a hospital, skilled nursing facility, extended care facility, wheel chair or have you been so confined for more than five consecutive days with the last twelve months?

3. ☐ Yes ☐ No Have you been advised that you will need to be admitted to a hospital, skilled nursing facility or extended care facility within the next six (6) months?

4. Within the past **three years** have you been treated for, diagnosed as having, or been recommended for future surgery, diagnostic testing or medical treatment, or thought you should seek medical advice for any of the following conditions. Each condition must be checked (✓) Yes or No.

☐ Yes ☐ No	AIDS, ARC or HIV
☐ Yes ☐ No	Alzheimer's Disease
☐ Yes ☐ No	Cancer or Malignant Melanoma
☐ Yes ☐ No	Cirrhosis of the Liver
☐ Yes ☐ No	Diabetes
☐ Yes ☐ No	Heart Disease (heart attack, bypass surgery, coronary artery disease, etc.)
☐ Yes ☐ No	Joint Replacement or Bone Disorder
☐ Yes ☐ No	Kidney Dialysis
☐ Yes ☐ No	Lung Disease (emphysema, chronic obstructive pulmonary disease, etc.)
☐ Yes ☐ No	Mental or Nervous Disorders
☐ Yes ☐ No	Parkinson's Disease
☐ Yes ☐ No	Stroke or Transient Ischemic Attack (TIA)

5. ☐ Yes ☐ No Are you currently taking any prescription medications? If yes, please complete the following. If additional medications, please attach a separate sheet.

Medication	Reason for taking	Dosage

SECTION VIII: BILLING INFORMATION

Please indicate how you would prefer to pay your premiums. Choose one:

☐ **HOME BILLING – Receive monthly premium billings**

☐ **FINANCIAL INSTITUTION – Have monthly automatic premium withdrawals**
If you wish to be billed through your financial institution, please complete the following authorization:

I authorize Medical Mutual of Ohio to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual of Ohio and my financial institution have received written notification from me within a reasonable time period to allow termination of the deduction.

Premiums are to be deducted from ☐ Checking ☐ Savings

Name and branch of bank/financial institution			Account Number
Address			Account Number
City	State	Zip	Transit Routing Number
Signature			Date

(Please note: not all financial institutions allow deductions from a saving account. Please verify this information with your financial institution.)

Attach cancelled check or deposit slip here.

☐ **DIFFERENT BILLING ADDRESS – Have home billing sent to a different address**
If your mailing address is different than your permanent address, complete the following:

Last Name (C/O)	First Name	MI
Address		
City	State	Zip Code

FOR OFFICE USE ONLY

Sold - Account Executive and Code
Service - Account Executive and Code

or

Agent of Record	Tax ID
Royal Advantage Broker	Commission Indicator

SECTION IX: TERMS AND CONDITIONS

While I am a Medical Mutual of Ohio subscriber, I hereby authorize the Medicare Part A and Part B carriers in Ohio to provide Medical Mutual with a copy of my Explanation of Medicare Benefits (EOMB) statements resulting from the payment of Medicare Part A and Part B claims.

I hereby authorize Medical Mutual to request and receive from any physician or medical institution, all records and information of medical examination, history and treatment for this applicant.

I acknowledge that I have received with this application a copy of the "Outline of Medicare Supplement Coverage" and "Guide to Health Insurance for People with Medicare". The outline explains the coverage options available.

I understand and agree that no agent or broker has the authority: (i) to bind MMO by making promises regarding eligibility, benefits, or the issuance of a policy; (ii) to waive any answer or any portion of any answer to any question on this application or any information MMO requests; (iii) approve coverage; (iv) make or alter any contract on behalf of MMO; or (v) waive or alter any of MMO's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of MMO to be binding on MMO.

I have read this entire Application and declare all information, statements, and answers to be true and complete. I understand that my coverage can be cancelled or rescinded by Medical Mutual if I have misstated or omitted any information.

Signature	Date

SECTION X: MEDICARE SELECT PLAN C APPLICANTS ONLY

FOR MEDICARE SELECT PLAN C, READ AND COMPLETE THE FOLLOWING:

I have read the Outline of Coverage and all other information included with this Application and understand that if I choose the Medicare Select Plan C policy:

I must use Medicare Select Network Hospitals for all inpatient services or my Medicare Select policy will not provide benefits for the Medicare Part A deductible. This penalty will not apply under the following circumstances:

- In an emergency or for urgently needed care when out of the Medicare Select Service Area.
- If an inpatient service is not available from a Medicare Select Network Hospital.

At my request, Medical Mutual will make available either the Medicare Supplement Plan A policy or the Medicare Supplement Plan C policy which do not contain a restricted network. If my Medicare Select Plan C policy has been in force for six (6) months Medical Mutual of Ohio will not require evidence of insurability.

If Medical Mutual should discontinue the Medicare Select Plan C policy, I will be offered the opportunity to purchase the Medicare Supplement Plan A policy or the Medicare Supplement Plan C policy without evidence of insurability.

Signature	Date

WARNING: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. (Ohio Revised Code Section 3999.21)