



MEDICAL MUTUAL OF OHIO®
Your healthcare partner since 1934

Supplement

Medicare Supplement Plans

from Medical Mutual

Enrollment Application

Important 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.
- 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 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 suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within ninety (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 the 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 reinstated if requested within ninety (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.
- 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 1: Contract Holder Information

Last Name	MI	First Name	Social Security Number
Birthdate	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Tobacco User: <input type="checkbox"/> Yes <input type="checkbox"/> No	Phone Number
Address			County
City	State	Zip Code	Email Address
Medicare Number	Medicare Part A Effective Date	Medicare Part B Effective Date	

Section 2: 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. When should coverage start:	Effective Date
---	----------------

Section 3: Products

Please select a Medicare Supplement Plan option (Check only one):
 Medicare Supplement Plan A Medicare Supplement Plan C Medicare Supplement Plan F

Section 4: Billing Information

Please indicate how you would prefer to pay your premiums (Choose one).
 1. Home Billing (Receive monthly premium billings)
 2. Different Billing Address (Have home billing sent to a different address)
 If your mailing address is different than your permanent address, please complete the following:

Last Name (C/O)	First Name	MI
-----------------	------------	----

Address	City	State	Zip Code
---------	------	-------	----------

3. Financial Institution (Automatic monthly premium withdrawals)
 If you wish to be billed through your financial institution, please complete the following authorization:
 I authorize Medical Mutual of Ohio (Medical Mutual) to initiate premium deductions from my account. The authorization will remain in effect until Medical Mutual 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 my:
 Checking Account Savings Account*

Name and branch of bank or financial institution

Account Number	Transit Routing Number
----------------	------------------------

Address	City	State	Zip Code
---------	------	-------	----------

Signature	Date
-----------	------

* **Please Note:** Not all financial institutions allow deductions from a savings account. Please verify this information with your financial institution.

Attach cancelled check or deposit slip here.

Section 5: Other Coverage Information

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. **Please answer all questions to the best of your knowledge.**

<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>1. (a) Did you turn age 65 in the last six (6) months? (b) Did you enroll in Medicare Part B in the last six (6) months? If "Yes," what is your effective date?</p> <p>Effective Date </p>																
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>2. (a) 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. (b) If you answered "Yes" to 2a, will Medicaid pay your premiums for this Medicare supplement policy? (c) Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?</p>																
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>3. (a) If you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g. 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 Date" blank.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Start Date</td> <td style="width: 30%;">End Date</td> <td style="width: 40%; background-color: #cccccc;"></td> </tr> </table> <p>(b) If you are still covered under the Medicare Plan, do you intend to replace your current coverage with this new Medicare supplement policy? (c) Was this your first time in this type of Medicare plan? (d) Did you drop a Medicare supplement policy with this policy to enroll in the Medicare plan?</p>	Start Date	End Date														
Start Date	End Date																
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<p>4. (a) Do you have another Medicare supplement policy in force? If so, what company and what plan do you have?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Company</td> <td style="width: 40%;">Plan</td> </tr> </table> <p>(b) If you answered "Yes" to 4a, do you intend to replace your current Medicare Supplement policy with this policy?</p>	Company	Plan														
Company	Plan																
<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>5. (a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual health plan). If so, what company and what plan do you have?</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">Company</td> <td style="width: 40%;">Plan</td> </tr> </table> <p>(b) If you answered "Yes" to 5a, what are your dates of coverage under the policy? If you are still covered under the policy, leave "End Date" blank.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%;">Start Date</td> <td style="width: 30%;">End Date</td> <td style="width: 40%; background-color: #cccccc;"></td> </tr> </table>	Company	Plan	Start Date	End Date												
Company	Plan																
Start Date	End Date																
	<p>6. Agent shall list any other health insurance policies agent has sold to the applicant. (a) List policies sold which are still in force. (b) List policies sold in the past five (5) years which are no longer in force.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Name of Plan</th> <th style="width: 30%;">Type of Coverage</th> <th style="width: 15%;">Start Date</th> <th style="width: 15%;">End Date</th> </tr> </thead> <tbody> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> <tr> <td> </td> <td> </td> <td> </td> <td> </td> </tr> </tbody> </table>	Name of Plan	Type of Coverage	Start Date	End Date												
Name of Plan	Type of Coverage	Start Date	End Date														

Section 7: Terms and Conditions

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)

While I am a Medical Mutual 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 Medical Mutual 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 Medical Mutual requests; (III) approve coverage; (IV) make or alter any contract on behalf of Consumers Life; or (V) waive or alter any of Medical Mutual other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Medical Mutual to be binding on Medical Mutual.

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

For Internal Use Only

Effective Date	Group Number	Sold (Account Executive and Code)	Service (Account Executive and Code)
Agent of Record	Royal Advantage Broker	Tax ID	Commission Indicator

Medical Mutual of Ohio
2060 East Ninth Street
Cleveland, OH 44107-1355