INDIVIDUAL MEDICARE SUPPLEMENT INSURANCE

Application Form

INSTRUCTIONS

- This is an application for Medicare Supplement Insurance underwritten by ConnectiCare Insurance Company, Inc. ("ConnectiCare"). It may be used to apply for new enrollment, or change in type of coverage. This application may be used to apply for one of our ConnectiCare Medicare Supplement Insurance Plans.
- **ConnectiCare cannot sell you a Medicare Supplement Insurance Plan if:**
  - **you already have a Medicare Supplement policy in force and you do not desire to replace the existing policy; or**
  - **the Medicare Supplement policy would duplicate benefits to which you are entitled under a Medicare Advantage plan.**
- **Return your completed application.** If you do not send payment with your application, we will send you an invoice after the application is processed and your eligibility has been confirmed. If you are submitting premium payment with this application, the policy will become effective once we determine that you are eligible for a Medicare Supplement insurance policy. We will provide coverage for benefits described in the policy, contingent upon insurability. We will determine if you are insurable no later than the date of completion of all parts of the application and the premium has been paid, unless you request a later effective date. If you request a later effective date, you understand that you may be waiving certain rights and guarantees under this conditional receipt. If the policy is not issued within this time, the application will be deemed rejected and all premiums will be refunded.
  - **If you are applying as a current ConnectiCare member who is switching to a ConnectiCare Medicare Supplement plan:** Coverage will be effective on the termination date of your previous ConnectiCare plan so you will not have a break in coverage. You must apply within 60 days of the termination date of your previous coverage in order for your Medicare Supplement plan to take effect on the termination date. You may apply after the 60-day period, but in that case you may have a break in coverage.
- **All applicants must:**
  a. Be residents of Connecticut.
  b. Complete the application statement, sign and date the application where indicated.
  c. Check the appropriate boxes for the coverage you are applying for.
  d. Return completed application and certificate(s) of creditable coverage to:

     ConnectiCare
     P.O. Box 2820 New York, NY 10116-2820

If you will be eligible for Medicare by reason of age only, we cannot accept your application more than 90 days prior to the month of your 65th birthday.

ConnectiCare

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PRINT IN INK

INDIVIDUAL APPLICATION FOR PERSONS ELIGIBLE FOR MEDICARE

Section I. Applicant Information

Social Security No.	Medicare Beneficiary Identifier (MBI)	
☐ I am/was a ConnectiCare member. My ConnectiCare ID number is: _____		
Applicant's Last Name	First Name	Middle Name
Home Address		County
City	State	ZIP Code
❑ Male ❑ Female	Date of Birth (Month/Day/Year):	
I understand that the phone numbers I provided on this application may be used by ConnectiCare or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.		
Tel #	Email Address	

Section II. Medicare Information

Date you became eligible for Medicare (Month/Day/Year):
Do you have Medicare Parts A and B now? ☐ Yes ☐ No If Yes, enter the effective date of Part A and the effective date of Part B: _____ _____ If Medicare Parts A and B are to be effective at a future date, please provide the date when both Medicare Parts A and B will be effective: _____ _____ *You must have both Medicare Parts A and B on the effective date of the policy; otherwise, the coverage cannot be issued.

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing 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 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 (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 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 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).

Section III. Enrollment/Guaranteed Issue Questions (Must be completed)

Please respond to questions 1 through 7 below to the best of your knowledge or belief:
(Please mark Yes or No below with an "X")

1	(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? ☐ Yes ☐ No If yes, what is the effective date? _____
2	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.) ☐ Yes ☐ No If yes, (1) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No (2) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No
3	(1) Have 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)? If Yes, fill in your start and end dates. (If you are still covered under the Medicare Advantage plan, leave END DATE blank) START DATE _____ END DATE _____ (2) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No (3) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No (4) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
4	(1) Do you have another Medicare Supplement or Medicare Select policy or certificate in force? ☐ Yes ☐ No (2) If so, with what company, and what plan do you have? _____ _____ (3) If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy? ☐ Yes ☐ No
5	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 (1) If so, with what company, and what kind of policy? _____ (2) What are your dates of coverage under the other policy? _____ If you are still covered under the policy, leave END DATE blank. START DATE _____ END DATE _____ (3) Do you intend to replace the coverage(s) you identify in this item 5 above with this Medicare Supplement policy or certificate? ☐ Yes ☐ No
6	I am applying for the following ConnectiCare Medicare Supplement Insurance Plan: (Check the appropriate box.) ☐ Plan A* ☐ Plan B* ☐ Plan F** ☐ Plan F+** ☐ Plan G ☐ Plan G+ ☐ Plan N *If you are under age 65 and have Medicare because of disability, you can only enroll in Plan A or Plan B. **You can enroll in Plan F and Plan F+ if you became eligible for Medicare before January 1, 2020. See Outline of Coverage for the applicable rates. **Proposed Effective Date (Month/Day/Year):** _____ I hereby apply for coverage of the type checked above. Coverage is effective as of the 1st of the month following approval of your completed application. To ensure continuation of coverage, you can request an initial effective date other than the 1st of the month. The effective date must be within 90 days of application signature. After the initial effective date, your policy will move to the 1st of the month anniversary date. **We must receive your premium payment for your coverage to be effective.** Plans F+ and G+ are high-deductible plans.
7	If you are replacing any in-force coverage with this Medicare Supplement policy or certificate, what is the reason you are replacing the coverage? ☐ Additional benefits ☐ No change in benefits, but lower premiums ☐ Fewer benefits and lower premiums ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D ☐ Disenrollment from a Medicare Advantage plan due to: _____ ☐ Other: (please explain) _____

Continued →

The ConnectiCare Medicare Supplement Insurance Plans impose a pre-existing condition limitation. If you have a pre-existing condition, that condition generally is not covered for the first six months after the effective date of coverage under the ConnectiCare Medicare Supplement Insurance Plan. A pre-existing condition is any condition for which medical advice was given or treatment was recommended by or received from a physician, within six months prior to the effective date of coverage.

In applying the pre-existing condition limitation, ConnectiCare will credit the time you were previously covered under creditable coverage if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new coverage. ConnectiCare will reduce the period of the pre-existing condition limitation by the aggregate of the period of creditable coverage without regard to the specific benefits covered during the period. Creditable coverage includes: a group health plan; health insurance coverage; Medicare; Medicare Supplement insurance; Medicare Select coverage; Medicare Advantage plan; Medicaid; TRICARE; medical programs of the Indian Health Service or a tribal organization; a State health benefits risk pool; Federal Employees Health Benefits Program; a public health plan; and a health benefit plan under Section 5(e) of the Peace Corps Act.

I represent and understand that:

A. The contract applied for will have the Effective Date specified on the contract schedule page. On that date, my existing Medicare Supplement or Medicare Advantage coverage, if any, shall be canceled.

B. All statements and answers in this application are true to the best of my knowledge and belief. This application will be made part of the contract, which will become effective on the date specified on the contract schedule page.

NOTE: BEFORE DATING AND SIGNING THIS APPLICATION, PLEASE MAKE SURE YOU HAVE ANSWERED ALL THE QUESTIONS. ALSO BE SURE YOU HAVE CHECKED THE APPROPRIATE BOX FOR THE TYPE OF COVERAGE YOU DESIRE.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim concerning any materially false information, or conceals for the purposes of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a criminal penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Print Name: _____ Signature: _____

Title: _____ Date: _____

Section IV. Insurance Agent Certification

To be completed by insurance agent only

Have you sold any other accident and health insurance plans to the applicant that are still in force?
☐ Yes ☐ No

Have you sold any other accident and health insurance plan policies to the applicant in the last five (5) years that are not still in force? ☐ Yes ☐ No

If Yes, please list any other health plan policies you have personally sold to the applicant that are still in force. If none, please write "none." Also, list any policies you sold to the applicant in the past five (5) years that are no longer in force.

Policy Description	**Policy Dates**

If the applicant is replacing health coverage with Medicare Supplement insurance coverage, please submit a completed ConnectiCare NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND HEALTH INSURANCE, HMO COVERAGE OR EMPLOYER-PROVIDED HEALTH BENEFIT ARRANGEMENT along with this application.

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.

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. I certify that the applicant has read, or I have read to the applicant, the completed application. To the best of my knowledge, the information on this application is complete and accurate.

Agency Name: _____

GA/FMO Name: _____ GA License Number: _____

Selling Agent Name: _____ Selling Agent License Number: _____

Agent Address: _____

Agent Email: _____ Agent Primary Phone: _____

Agent Fax: _____

Agent Signature: _____

(For ConnectiCare Office Use Only)

	Current ConnectiCare Member
Date Application Issued ..... _____	Date Application Received ..... _____
Date Application Processed ..... _____	Date, Contract, and Copy of Application Sent ..... _____
Type of Plan ..... _____	Group Number ..... _____
	Effective Date ..... _____

ConnectiCare

Notice to Applicant Regarding Replacement of
Medicare Supplement Insurance or Medicare Advantage Plan

ConnectiCare Insurance Company, Inc.
55 Water Street, 12th Floor, New York, NY 10041-8190

Save This Notice! It May Be Important to You in the Future.

According to information you have provided, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage plan and replace it with a policy to be issued by ConnectiCare Insurance Company, Inc. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker, or Other Representative:
I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage, because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.

☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

☐ Other (please specify) _____

1 **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2 State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3 If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the Application concerning your medical and health history. Failure to include all material medical information on an Application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the Application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Signature of Agent, Broker, or Other Representative* Print Name of Issuer, Agent, or Broker

_____ _____ _____
Applicant's Signature Date Print Address of Issuer, Agent, or Broker

*Signature not required for direct response sales.

Print Clear Form