Enrollment Application

Important Information

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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.
6. 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).

Applicant Information (Please print)			U/W approval Y N Area Code_____
Last Name	First Name	MI	Home Number ( )
Sex ☐ Male ☐ Female	Broker Name/Writing Code	Birthdate	Cell Number *optional* ( )
Address			County
City	State	Zip	Email Address
Medicare Beneficiary Number	Medicare Part A Effective Date		Medicare Part B Effective Date

Effective Date	
The effective date for your Medicare Supplement Plan is the first of the month following our receipt of the completed application.	Effective Date: Age on Effective Date:

Please select a Medicare Supplement Plan option:

☐ Plan A ☐ Plan F ☐ Plan High Deductible F ☐ Plan G ☐ Plan High Deductible G

☐ Plan M ☐ Plan N

Billing Information

How would you prefer to pay your premiums?

☐ Receive a monthly bill ☐ Automatic Monthly Premium Withdrawals (complete below)*

If you choose automatic monthly premium withdrawals, please complete the following authorization and include a voided check or blank savings deposit slip with your application.

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

☐ Checking Account ☐ Savings Account	Name of Bank or Financial Institution
Account Number	Routing Number
Applicant Signature	Date

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

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 for 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,	
1. (a) ☐ Yes ☐ No	Did you turn age 65 in the last six (6) months?
(b) ☐ Yes ☐ No	Did you enroll in Medicare "Part B" in the last six (6) months? (c) If "Yes," what is the effective date?
2. ☐ Yes ☐ No	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 no, skip to Question 3)*
(a) ☐ Yes ☐ No	If yes to question 2, will Medicaid pay your premiums for this Medicare supplemental policy?
(b) ☐ Yes ☐ No	If yes to question 2, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
3. (a)	If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, 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. Start Date: End Date:
(b) ☐ Yes ☐ No	If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
(c) ☐ Yes ☐ No	Was this your first time in this type of Medicare plan?
(d) ☐ Yes ☐ No	Did you drop a Medicare supplement policy to enroll in the Medicare plan?
4. (a) ☐ Yes ☐ No	Do you have another Medicare supplement policy in force?
(b)	If so, with what company, and what plan do you have (A, F, etc.)? Company: Plan:
(c) ☐ Yes ☐ No	If so, do you intend to replace your current Medicare supplement policy with this policy?

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5. ☐ Yes ☐ No	Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)			
(a)	If so, with what company and what kind of policy? Company: Policy Type:			
(b)	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:	
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.			
	Plan Name	Type of Plan	Start Date	End Date

Guaranteed Issue for Eligible Persons

Guaranteed Issue means an insurer shall not deny or condition the issuing of, or effective date of, a Medicare Supplement policy; shall not discriminate in the pricing because of health status, claims experience, or medical condition; and shall not impose an exclusion of benefits based on a pre-existing condition.

You may be eligible for Guaranteed Issue if you:

- Are within your initial enrollment period for Medicare, or
- Already have Medicare, were enrolled in an employer benefit plan which was terminated, or
- Already have Medicare, were enrolled in a Medicare Advantage plan or COST plan which was terminated, or
- Already have Medicare and another Medicare Supplement plan that was terminated

You may skip the medical questions on pages 5 and 6 if you answer yes to any of the following questions:

☐ Yes ☐ No Will this coverage start 3 months before or after your 65th birthday?

☐ Yes ☐ No Will this coverage start when you are age 65 or older and within 6 months of your Medicare Part B coverage effective date?

☐ Yes ☐ No Are you involuntarily losing employer group insurance and are older than 65 years and 6 months?

☐ Yes ☐ No Did you receive a letter of Guaranteed Issue?

You do not need to complete the questions on pages 5 and 6 if you answered yes to any Guaranteed Issue question on the bottom of page 4.

Medical Questions—If you answer yes to the questions below, please provide an explanation in the space provided on page 6.

1. ☐ Yes ☐ No	Are you currently confined to a hospital, skilled nursing facility, extended care facility, wheelchair or have you been so confined for more than five consecutive days within the last twelve months?
2. ☐ Yes ☐ No	Have you been advised that you will need surgery, therapy, a prescription or procedure as a result of a recent treatment or diagnosis?
3. ☐ Yes ☐ No	Have you been treated for or diagnosed as having AIDS, ARC, or HIV?

4. Within the past 5 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 marked "yes" or "no".)

☐ Yes ☐ No Alzheimer's Disease	☐ Yes ☐ No Aneurysm
☐ Yes ☐ No Cancer or Malignant Melanoma	☐ Yes ☐ No Cirrhosis of the liver
☐ Yes ☐ No Diabetes	☐ Yes ☐ No Down Syndrome
☐ Yes ☐ No Heart Disease	☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Kidney Dialysis	☐ Yes ☐ No Leukemia
☐ Yes ☐ No Multiple Sclerosis	☐ Yes ☐ No Muscular Dystrophy
☐ Yes ☐ No Open Heart Surgery Candidate	☐ Yes ☐ No Polycystic Kidney Disease
☐ Yes ☐ No Renal Failure	☐ Yes ☐ No Spinal Disorders
☐ Yes ☐ No Tumors	☐ Yes ☐ No Parkinson's Disease
☐ Yes ☐ No Lou Gehrig's Disease	☐ Yes ☐ No Other Conditions
☐ Yes ☐ No Lung Disease (emphysema, chronic obstructive pulmonary disease, etc.)	
☐ Yes ☐ No Organ Transplant Type:	Date:
☐ Yes ☐ No Stroke or Transient Ischemic Attack (TIA)	

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5. ☐ Yes ☐ No	Are you currently taking any prescription medications? If yes, please complete the following. If more space is needed, please use the space provided below question #8.		
	Medication	Reason for Taking	Dosage
6. ☐ Yes ☐ No	Has any insurance company refused or restricted any health coverage on you within the past 5 years?		
7. ☐ Yes ☐ No	Have you abused or had a dependency of alcohol or drugs in the past 5 years?		

If you answered "yes" to any of the medical questions on pages 5 or 6 please include an explanation here.

Question #	Condition	Treatment Dates	Doctor's Name and Details

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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.
- I hereby apply for this coverage through the AultCare Insurance Company. I further agree to participate in such coverage and agree to be bound to the relevant terms of my Certificate of Insurance.
- All information in this application, to the best of my knowledge, is complete, true and accurate. I give my consent to AultCare Insurance Company or its affiliated companies or authorized designees to request from any provider of medical, dental or pharmacy services, any insurance company or organization, to release medical records, billing records, or any information requested with regard to any claim and/or expense reported regarding my condition.
- I consent to allow AultCare Insurance Company and its authorized employees and agents to use and disclose my protected health information to any other insurance company or health plan, any state or federal agency providing health care benefits, and other persons or organization that perform professional, business, or insurance functions for AultCare Insurance Company such as independent claims examiners or group plan administrators or reinsurers. I understand that this information may be used for purposes that include but are not limited to: processing my application for enrollment; individual risk classification; detecting or preventing fraud; internal and external audits; administration of claims; case management; quality improvement programs, reviews, and audits; public health reporting; peer review; utilization review; coordination of benefits; subrogation; health promotion; disease management and prevention; and any other managed care and prevention program. I authorize AultCare Insurance Company to use and disclose my protected health information to be covered, including but not limited to information from and concerning: mental health records; substance abuse records; reproductive health; information relating to HIV virus or AIDS; sexually transmitted or other communicable diseases. This authorization shall be effective for a period of thirty (30) months from the date of my signature below. I understand that I and any person authorized to act on my behalf are entitled to a copy of this authorization.

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For Internal Use Only

Effective Date: _____ Group Number: _____

Agent/Sales Representative: _____

Agent/Sales Representative Print Name: _____

Cornerstone Writing Code: _____ Area Code: _____

U/W Approval Yes _____ No _____

- I acknowledge that I have received with this application a copy of the “Outline of Coverage” and "Guide to Health Insurance for People with Medicare".
- I have read all of the statements contained in this application and declare by signing this application the information I have provided is true and complete to the best of my knowledge.

Applicant Signature:_____Date:_____

Applicant Printed Name:_____

AultCare Insurance Company, or a vendor on behalf of AultCare Insurance Company, may contact you for demographic, satisfaction, and/or medical management information in accordance with its obligations under Federal Law. FCC TCPA Ruling 2015

You may mail the completed application to:
PrimeTime Choices
PO Box 9975
Canton, OH 44711

Or a drop box is available at our office location:
PrimeTime Choices
Morrow House Building
2600 6th St SW
Canton, OH 44710

Be sure to include pages 2 through 8 of the application, a copy of the Guaranteed Issue letter (if applicable), a copy of your Medicare card, a check for your first month’s premium, and if you elected automatic payment withdrawals, a voided check or voided savings deposit slip.

PrimeTime Choices
AultCare Insurance Company
Morrow House
2600 Sixth St SW
Canton, Ohio 44710
(330) 363-4031
(877) 863-1791
TTY: 711

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

PrimeTime Choices
offered by AultCare Insurance Company
o 5
Canton, Ohio 4471
(330) 363-4031 or (877) 863-1791

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by AultCare Insurance Company. 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 or Agent

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 Part D.

___Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____

___Other

_____

_____

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

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, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to pre-existing condition, 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 or Other Representative*

_____

_____

_____

Typed Name and Address of Issuer/Agent/Representative

_____ _____

Applicant's Signature Date

*Signature not required for direct response sales