APPLICATION FORM
Alliance Medicare Supplement Plan

Alliance Medicare Supplement
Alliance Health and Life Insurance Company

Call Toll-Free (800) 868-3153

Alliance Health and Life Insurance Company
Attn: Underwriting & Rating
2850 W. Grand Blvd.
Detroit, MI 48202

1 TELL US ABOUT YOURSELF

First and Last Name

Address

City | State | Zip

Social Security Number - -

Birth Date M M D D Y Y Y Y

Gender ○ M ○ F

E-mail Address (Optional)

Medicare Claim Number
(as shown on Medicare Health Insurance Card)

( ) -
Area Code Phone

2 SELECT THE ALLIANCE MEDICARE SUPPLEMENT PLAN THAT BEST MEETS YOUR NEEDS

Please check the appropriate circle for the plan you are applying for:

○ **Plan A** ○ **Plan C** ○ **Plan F** ○ **Plan N**

- Please refer to the enclosed brochure for the monthly cost of the plan and description of the plan offering.
- **You are eligible to apply if you are a Medicare beneficiary, age 65 or older, enrolled in Medicare Parts A and B and do not have more than one Medicare supplement policy.**
- **Your coverage will become effective on the first day of the month following receipt and approval of your completed enrollment application.** You will receive a Certificate of Insurance confirming your effective date. (**If you would like your coverage to begin at a later date**, please indicate below.)

Requested Effective Date (first of the future month)
Your application must be received 30 days prior to your requested effective date.

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Questions? Call Toll-Free (800) 868-3153 and talk to a Alliance Medicare Supplement Plan Customer Service Representative

3 YOUR ACCEPTANCE MAY BE GUARANTEED

	YES	NO
a) Did you turn age 65 in the last 6 months?	○	○
b) Did you enroll in Medicare Part B within the last 6 months?	○	○

If YES, what is the effective date? M M D D Y Y Y Y

If you answered YES to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP TO NUMBER 5.

c) Have you lost other health insurance coverage and, if so, are you an eligible person as defined within the termination notice you received from your prior insurer? If the answer is "yes", you may be guaranteed acceptance in certain Alliance Medicare Supplement Plans. Please **include a copy of the termination notice** with your application and **SKIP TO NUMBER 5**.	○	○

If you answered YES to a, b or c above, you are applying for coverage during an open enrollment or guaranteed issue period. Please skip Section 4 and proceed to Section 5.

4 COMPLETE SECTION 4

	YES	NO
a. Are you currently a smoker or have you been a smoker within the past 6 months?	○	○
b. Have you, due to mental or physical disability, authorized any person or institution to legally act in your behalf and take over your personal business transactions?	○	○
c. In the past 12 months, have you been told you will need surgery but it has not yet been done?	○	○
d. In the past 12 months, have you been hospitalized three or more times?	○	○
e. Do you visit any medical provider more than monthly for medical advice or treatment?	○	○
f. Do you now have any of the following conditions or have you received medical advice or treatment for the following conditions within the past 12 months?		
(1) Cancer (except skin) or Leukemia	○	○
(2) Chronic Lung Disease	○	○
(3) Cirrhosis of the Liver	○	○
(4) Diabetes (insulin dependent)	○	○
(5) Stroke	○	○
(6) Angina Pectoris, Heart Attack, Congestive Heart Failure, or Valvular Heart Disease	○	○
(7) Alzheimer's Disease	○	○
(8) Parkinson's Disease	○	○
(9) Multiple Sclerosis	○	○
g. Do you have end stage renal disease, or are you currently receiving dialysis, or have you been diagnosed, within the past 90 days, with kidney disease that requires dialysis?	○	○

5 FOR YOUR PROTECTION YOU ARE REQUIRED TO READ THE STATEMENTS BELOW, ANSWER ALL THE QUESTIONS AND SIGN WHERE INDICATED

(1) You do not need more than 1 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) If you are 65 or older, 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 will be suspended 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 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 medicaid.

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.**

		YES	NO
(1)	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 yes,		
(a)	Will medicaid pay your premiums for this medicare supplement policy?	○	○
(b)	Do you receive any benefits from medicaid OTHER THAN payments toward your medicare part B premium?	○	○
(2) (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" blank. START _____/_____/_____ END _____/_____/_____		
(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 to enroll in the medicare plan?	○	○

5 (CONTINUED)

		YES	NO
(3)	(a) Do you have another medicare supplement policy in force?	○	○
	(b) If so, with what company, and what plan do you have? _____		
	(c) If so, do you intend to replace your current medicare supplement policy with this policy?	○	○
(4)	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? _____		
	(b) What are your dates of coverage under the other policy? START _____/_____/_____ END _____/_____/_____ (If you are still covered under the other policy, leave "END" blank.)		

6 IF THIS POLICY IS SOLD BY AN AGENT, THE AGENT SHALL LIST OTHER HEALTH COVERAGE SOLD TO THE APPLICANT.

Policies still in force _____

Policies no longer in force and sold in the last five years _____

7 IMPORTANT ACKNOWLEDGMENT. AUTHORIZATION AND VERIFICATION INFORMATION. PLEASE READ CAREFULLY, SIGN AND DATE WHERE INDICATED.

- My signature below indicates that I have read and understand the contents of this application.
- I acknowledge receipt of the Alliance Medicare Supplement product brochure (Outline of Coverage), and *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*.
- I declare that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are incomplete, incorrect or untrue, Alliance Health and Life Insurance Company may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties.
- I understand that the coverage under the plan I am applying for will not take effect until issued by Alliance Health and Life Insurance Company.

Authorization: for the Release of Medical Information.

To: Any licensed physician, medical practitioner, hospital, pharmacy, clinic, or like facility; insurance company; or other organization, institution, or person. I authorize you to give Alliance Health and Life Insurance Company any data or records you may have about me or my mental or physical health. Alliance Health and Life Insurance Company needs this data to find out if I qualify for health insurance and to administer my coverage if accepted. For purposes of determining my qualification for coverage, this authorization is valid for 24 months from the date of my signature. For claims processing, this authorization is valid for the term of the coverage.

Note: Please type your full name in the 'Your Signature' field if submitting online.

If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

✗ _____ _____

YOUR SIGNATURE (REQUIRED) DATE (REQUIRED) M M D D Y Y Y Y

✗ _____ _____

AGENT (NAME REQUIRED) DATE (REQUIRED) M M D D Y Y Y Y

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