



CAROLINA CARE PLAN[®]
A MEDICAL MUTUAL OF OHIO COMPANY

Medicare Supplement Plans

Supplement

from Carolina Care Plan

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 Carolina Care Plan's receipt of the completed application. When should coverage start:	Effective Date
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Section 3: Products

Please select a Medicare Supplement Plan option (CHECK ONLY ONE):

Medicare Supplement Plan A
 Medicare Supplement Plan B
 Medicare Supplement Plan C
 Medicare Supplement Plan F
 Medicare Supplement High-Deductible 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	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 Carolina Care Plan to initiate premium deductions from my account. The authorization will remain in effect until Carolina Care Plan 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 on the 1st business day of the month 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. In case of insufficient funds a \$20 returned check fee will be applied.

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	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?		
	Effective Date		
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	2. (a) 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. (b) If "Yes," 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?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	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" blank.		
	Start	End	
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	(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?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. (a) Do you have another Medicare Supplement policy in force? If so, what company and what plan do you have?		
	Company	Plan	
<input type="checkbox"/> Yes <input type="checkbox"/> No	(b) If so, do you intend to replace your current Medicare Supplement policy with this policy?		
<input type="checkbox"/> Yes <input type="checkbox"/> No	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?		
	Company	Plan	
<input type="checkbox"/> Yes <input type="checkbox"/> No	(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" blank.		
	Start	End	
	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.		
	Name of Plan	Type of Coverage	Start Date
			End Date

Section 6: Medical Eligibility

IMPORTANT NOTICE: You do not have to complete this section if:

- 1. This application is being submitted within six (6) months from the month in which you first enrolled for benefits under Medicare Part B; or**
- 2. You have lost other health coverage which would qualify you for guaranteed acceptance. (Note: To be considered for guaranteed acceptance, Carolina Care Plan must receive your application, along with a copy of the termination notice you received from your prior insurer, within 63 days of termination of your prior coverage.)**

<input type="checkbox"/> Yes <input type="checkbox"/> No	1. 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 Date	End Date	Physician
<input type="checkbox"/> Yes <input type="checkbox"/> No	2. 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 within the last twelve months?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	3. 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?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	4. Within the past three years have you been treated for or diagnosed as having AIDS, ARC or HIV?			
<input type="checkbox"/> Yes <input type="checkbox"/> No	5. 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.")			
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Alzheimer's Disease		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer or Malignant Melanoma		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cirrhosis of the Liver		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Diabetes		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Disease		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint Replacement or Bone Disorder		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Dialysis		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lung Disease (emphysema, chronic obstructive pulmonary disease, etc.)		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mental or Nervous Disorders		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Parkinson's Disease		
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke or Transient Ischemic Attack (TIA)		
<input type="checkbox"/> Yes <input type="checkbox"/> No	6. 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 7: Tobacco Use

Yes **No** Have you used tobacco, in any form, in the last 12 months?

Section 8: Terms and Conditions

WARNING: 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 may commit a fraudulent insurance act, which is a crime and subjects such persons to criminal and civil penalties.

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

I authorize: release of information, without limitation, from any medical/medically related facility, prior health insurance carrier, the Medical Information Bureau, Inc. (MIB), prescription history database supplier, government agency or person to Carolina Care Plan and/or any affiliates or division of Carolina Care Plan: (a) to evaluate this Application; (b) to adjudicate claims submitted on behalf of me or my dependents; (c) for utilization review programs to monitor health services or quality improvement activities and/or; (d) for credentialing purposes. I authorize Carolina Care Plan to provide a photocopy of this release to any physician or medical institution to obtain records for the purposes stated above. This authorization will be valid for a period of two and one-half years for the purpose of collecting information regarding this Application.

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: (1) to bind Carolina Care Plan by making promises regarding eligibility, benefits, or the issuance of a policy; (2) to waive any answer or any portion of any answer to any question on this Application or any information Carolina Care Plan requests; (3) approve coverage; (4) make or alter any contract on behalf of Carolina Care Plan; or (5) waive or alter any of Carolina Care Plan's other rights or requirements. All contract terms must be in writing and signed or accepted in writing by an authorized representative of Carolina Care Plan to be binding on Carolina Care Plan.

I understand and agree that any information obtained will not be released by Carolina Care Plan to any person or organization except to reinsuring companies, the MIB, or other persons or organizations performing health care operations or business or legal services in connection with any application, claim, or as may be otherwise lawfully required, or as we may further authorize. Once personal and health information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient, and the information may not be protected by federal and state privacy requirements. A copy of this authorization request is available to me or my legal representative upon written request. A photographic copy of this authorization shall be as valid as the original. This authorization shall be valid for a period of two and one-half years. I have the right to revoke this authorization at any time. To revoke this authorization, I must do so in writing and send my written revocation to Carolina Care Plan's Privacy Office. The revocation will not apply to information that has already been released in response to this authorization. The revocation may adversely affect my Application, a claim or a pending insurance action. The revocation will become effective after it is received by Carolina Care Plan's Privacy Office.

I understand and acknowledge that this authorization extends to all medical records, including records which may contain information regarding treatment for physical and mental illness, alcohol/drug abuse and/or HIV-AIDS test results or diagnosis. I expressly consent to the release of such information.

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 Carolina Care Plan if I have misstated or omitted any information.

Signature

Date

Print Name

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

Carolina Care Plan
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Visit CarolinaCarePlan.com.