



# Medicare Supplement Application

**COMPLETE APPLICATION IN FULL ♦ USE BALLPOINT PEN ♦ PRINT LEGIBLY**  
 New West Health Services will be hereafter referred to as "New West."

### I. Product Selection (Select One)

- |                                 |                                 |                                 |
|---------------------------------|---------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan F | <input type="checkbox"/> Plan I |
| <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan H | <input type="checkbox"/> Plan J |

### II. Current Age Group (Select One)

- |  |  |
|--|--|
| <input type="checkbox"/> Age 65 through 66 | <input type="checkbox"/> Age 75 through 79 |
| <input type="checkbox"/> Age 67 through 69 | <input type="checkbox"/> Age 80 through 84 |
| <input type="checkbox"/> Age 70 through 74 | <input type="checkbox"/> Age 85 and over   |

### III. Applicant's Information

Last Name		First Name		Middle Initial
Mailing Address				
City	State	ZIP	Social Security Number	
Daytime Telephone Number (include area code)			Evening Telephone Number (include area code)	
Date of Birth:		Height:		Weight:

### IV. 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 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 the following questions to the best of your knowledge:

	Yes	No
1. Are you presently covered under both Medicare Parts A and B?	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ⓜ If you answered Yes, you must enclose a copy of your Medicare identification card.</b>		
2. Did you first enroll in Medicare Part B in the last 6 months? → If you answered Yes, please give date of enrollment: Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have another Medicare Supplement contract, policy or certificate in force?	<input type="checkbox"/>	<input type="checkbox"/>
4. a.) Did you turn age 65 in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
b.) Did you enroll in Medicare part B in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
c.) If yes, what is the effective date? Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
d.) Did you enroll in Medicare part C in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
e.) If yes, what is the effective date? Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>
f.) Did you enroll in Medicare part D in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
g.) If yes, what is the effective date? Date: ____/____/____	<input type="checkbox"/>	<input type="checkbox"/>



### IV. Other Coverage Information (Continued)

Please answer the following questions to the best of your knowledge:	<b>Yes</b>	<b>No</b>
8. Are you a Medicare recipient on Social Security Disability?	<input type="checkbox"/>	<input type="checkbox"/>

### V. Health Information

**IMPORTANT NOTICE:** An "Open Enrollment" Applicant will not be denied issuance of the policy applied for on the basis of Health Status or Medical Conditions. An Open Enrollment Applicant is any person for whom this Application is submitted during the 6-month period beginning with the first month in which the Applicant who is 65 years of age or older first enrolled under Medicare Part B. However, the 6-month waiting period for pre-existing conditions may apply.

Please answer the following questions (Disregard this section if you are applying during your Medicare Open Enrollment period):	<b>Yes</b>	<b>No</b>
1. Are you currently hospitalized (including confinement to a nursing facility) or receiving Medicare approved home health care; or have you been hospitalized or received Medicare approved home health care 2 or more times in the past 12 months?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you currently scheduled for surgery, hospital confinement or nursing home confinement?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever been advised to have an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you bedridden or confined to a wheelchair, do you require a walker, or, during the past 2 years, have you had any type of amputation caused by disease?	<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past 2 years, have you been medically advised to have surgery for cataracts, joint replacement, a heart condition, prostate condition, or urinary incontinence, but have not yet had the surgery?	<input type="checkbox"/>	<input type="checkbox"/>
6. Within the past 2 years, have you been treated for, medically diagnosed as having, been advised by a physician to have treatment or surgery regarding, or advised to take prescription medication for:		
a.) Cancer (including but not limited to melanoma, leukemia, Hodgkin's disease)?	<input type="checkbox"/>	<input type="checkbox"/>
b.) Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	<input type="checkbox"/>	<input type="checkbox"/>
c.) Parkinson's disease, multiple sclerosis, muscular dystrophy, Amyotrophic Lateral Sclerosis (ALS), or crippling or debilitating arthritis?	<input type="checkbox"/>	<input type="checkbox"/>
d.) Insulin-dependent diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
i. Myasthenia Gravis or any other autoimmune disorder?	<input type="checkbox"/>	<input type="checkbox"/>
ii. Enlarged heart, heart or coronary artery disease, heart valve, congestive heart failure, stroke or heart rhythm disorder?	<input type="checkbox"/>	<input type="checkbox"/>
iii. Mental or nervous disorder requiring psychiatric care, Alzheimer's disease, senile dementia, or organic brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>
iv. Kidney failure or end stage renal disease?	<input type="checkbox"/>	<input type="checkbox"/>
v. Kidney dialysis or transplant?	<input type="checkbox"/>	<input type="checkbox"/>
vi. Cirrhosis of the liver, alcoholism, or drug addiction?	<input type="checkbox"/>	<input type="checkbox"/>

1. If you answered Yes to any of the preceding Health Information questions (including all subparts), please provide the following information (attach additional sheets as necessary):

Question Number	Specific Condition/ Injury	Treatment Dates		Provider Name Address City State ZIP Code	Medications	Current Status of Condition/ Injury
		From	To			

### V. Health Information (Continued)

2. Please list all prescription medications which have been filled or for which prescriptions have been issued in the past 6 months (attach additional sheets as necessary):

Name of Medications	Dosage	Treatment Dates		Specific Condition/ Injury	Provider, Name, Address, City, State, ZIP Code
		From	To		

10. Please describe all medical treatment, diagnosis, and/or advice you have received in the past 6 months:

Specific Condition/ Injury	Treatment Dates		Hospitalized?	Provider, Name, Address, City, State, ZIP Code
	From	To		

11. Please list the name, address & telephone numbers of all providers who have your medical records:

Provider Name Address City State ZIP Code	Date of Last Visit

### VI. Payment Information

<b>Payment Frequency</b>	<input type="checkbox"/> Monthly (EFT or Credit Card only) <input type="checkbox"/> Semi-annual <input type="checkbox"/> Annual
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### VII. Payment Method

<input type="checkbox"/> Check	I would like to pay the premiums by check. I understand that checks are accepted for a billing frequency of semi-annual or annual only. Monthly payments may be made through electronic bank drafts or credit cards.			
<input type="checkbox"/> Bank Draft Option (EFT)	I would like my premium charged to my bank account and have attached a voided check. I have completed Part VIII below.			
	Type of account <input type="checkbox"/> Checking <input type="checkbox"/> Savings	Name of Bank	Bank Routing Transit Number	Bank Account Number
<input type="checkbox"/> Credit Card Option	I would like my premium charged to my credit card. I have completed Part VIII below.			
	Type of Credit Card: <input type="checkbox"/> Visa/MC <input type="checkbox"/> Discover <input type="checkbox"/> AMEX <input type="checkbox"/> Other: _____		Credit Card Number	

### VIII. Credit Card/Bank Draft (EFT) Payment Agreement

I hereby authorize New West to initiate a charge to my credit card/bank account payable to the order of New West for all premiums due at any time, if this Application is accepted. I agree that New West's rights in respect to each such credit card charge/bank draft shall be the same as if it were a check drawn on my bank account and signed by me personally. This authority is to remain in effect until the last applicable premium is paid, or until revoked by me in writing and received by New West, whichever is sooner. I agree that if such charges are dishonored, with or without cause, intentionally or inadvertently, New West shall have no liability whatsoever even though such dishonor results in forfeiture of insurance. I understand that the first month's premium will be charged upon this Application's acceptance, and that my credit card/bank account will not be charged if this Application is declined.

Name and Address of Credit Card/Bank Account Holder (Print):

Signature of Account Holder (It must be EXACTLY as it appears on credit card/bank account records)

Relationship of Applicant to Account Holder:

### IX. Application Agreement (Please Read Carefully)

**I, the Applicant, understand and agree that:**

1. This is an Application only. No rights to coverage are conferred me until New West accepts my Application, issues a Medicare Supplement policy to me and the applicable premiums are paid.
2. I should not cancel any existing insurance or coverage unless and until I am notified in writing by New West of my acceptance for coverage. I acknowledge that I may not be accepted for coverage.
3. New West relies upon the information I provided on this Application and any other information I provided for New West to make a determination about issuing coverage. If the information in the Application is not accurate, coverage may be denied or any policy issued to me may be cancelled retroactively to the original effective date.
4. Premiums for my coverage must be paid on time in accordance with the selected payment option I selected above. Acceptance of premium by New West does not constitute a waiver of New West's rights to retroactively cancel my coverage for omissions, misrepresentations, fraud, or concealment of any facts on this Application. If such a retroactive cancellation occurs, New West may deduct benefit payments from any paid premium before refunding such premiums to me. I agree to repay any benefit payments to which I was not entitled.

### IX. Application Agreement (Continued)

5. I am a resident of Montana and accept the terms and conditions of any policy issued to me by New West.
6. I have received the New West Notice of Privacy Practices.
7. If a broker or agent is handling this coverage request, the broker or agent does not have the authority to bind or commit New West in any manner.
8. New West may need to obtain medical records on me. I agree to cooperate with New West to obtain any information (including completing an authorization) it needs to review my Application.
9. I authorize the transfer of claims information from Medicare to New West.

I certify that all of the information provided in this Application or other information provided to New West by me is true, complete, and correct.

I hereby apply for coverage with New West and agree that the coverage for which I am applying is subject to eligibility requirements, and the policy effective date will be assigned by New West. I have read, understand and agree to the terms of the Application Agreement.

**Applicant's Signature:**

**Date:**

**X. To Be Completed By Your New West Representative/Producer**

The New West Representative/Producer is required to answer the following:		<b>Yes</b>	<b>No</b>
1. I have advised the Applicant to read, fully complete and sign this Application for Medicare Supplement coverage to the best of the Applicant's knowledge and ability.		<input type="checkbox"/>	<input type="checkbox"/>
2. I have advised the Applicant that coverage will not commence until he/she is notified that his/her Application has been received and accepted by New West.		<input type="checkbox"/>	<input type="checkbox"/>
3. A copy of the "Notice to Applicant Regarding Replacement of Medicare Supplement Coverage" (fully executed), Guide to Health Insurance for People with Medicare, and an Outline of Coverage has been provided to the Applicant.		<input type="checkbox"/>	<input type="checkbox"/>
4. List all medical or health insurance policies you have <u>ever</u> sold to the Applicant that are still in force (attach additional sheets if needed):			
Type of Policy		Name of Insurance Company	
5. List all medical or health insurance policies you have sold to the Applicant <u>in the past five years</u> (identify type of policy and company name) regardless of whether the policies are still in force (attach additional sheets as needed):			
Type of Policy		Name of Insurance Company	
6. I certify that I received from the Applicant the Sum of \$ _____, which is the full initial premium for _____ months. I have explained to the Applicant that if, for any reason, the Application is not approved and the Medicare Supplement policy is not issued, the total payment will be refunded, and that no liability is created or assumed by New West, except for the refund of this payment, until and unless the policy applied for has been issued.			
<b>I certify the following:</b>			
1. I have responded truly and correctly to the above statements; and			
2. I am not aware of any information not disclosed in the Application that might have a bearing on the Applicant's eligibility. I have explained to the Applicant that the policy cannot be issued to persons who answered "No" to question number 6 in Part IV <u>and/or</u> "Yes" to question number 7 in Part IV of this Application.			
<b>Signature of Representative:</b>		<b>Date:</b>	
<b>Printed Name:</b>		<b>Telephone #:</b>	

Instruction to Representative/Producer: A copy of this Notice must be given to the Applicant if her/she marks "Yes" to question 3 in Part IV, indicating that this Application is for the purpose of replacing existing health coverage, and this form must be signed by the Applicant and you. ✓ You must provide the Applicant a copy of this Notice.

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

**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 supplement insurance and replace it with a policy to be issued by New West Health Services. 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 policy carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare Supplement or Medicare Advantage coverage is a wise decision.

**STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:**

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 only):

- No change in benefits, but lower premium
- Additional benefits
- 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.
- Fewer benefits and lower premiums
- 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 (preexisting 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 policy, whereas a similar claim might have been payable under your present policy.

(2\*) State law provides that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The company will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy as long as you have not allowed your policy to lapse for over 31 days.

(3) If you still wish to terminate your present policy and replace it with new policy, be certain to truthfully and completely answer all questions on the Application concerning your medical/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.

\*Paragraphs (1) and (2) of this Notice (applicable to pre-existing conditions) do not apply to Applicants who have previously satisfied waiting periods, and no new preexisting condition limitation will be applied.

<b>Producer</b>	Signature of Producer or Other Representative	Producer's Typed Name and Address
<b>Applicant</b>	The above "Notice to Applicant" was delivered to me on _____, 20__.	
	Signature of Applicant (Applicant's signature is not required for direct response sales.)	Date