Alliance Health and Life Insurance Company

2027 Application – Alliance Medicare Supplement Plan

Health Alliance Plan® by Henry Ford Health

All sections must be completed unless otherwise indicated.

1 Tell us about yourself

First, Middle Initial and Last Name: _____ / _____ / _____

Gender: ☐ M ☐ F | Birthday: ___/___/_____ (MM/DD/YYYY) Social Security Number: _____ - _____ - _____

Phone Number: (_____) _____ - _____ Email Address: _____

Address: _____

City: _____ State: _____ ZIP: _____

Please refer to your Medicare Health Insurance card for the following information:

Medicare Number: _____

Part A and B Effective date A: ___/___/_____ (MM/DD/YYYY) B: ___/___/_____ (MM/DD/YYYY)

2 Select the Alliance Medicare Supplement Plan that best meets your needs

Your plan choices are based on your age and other factors, like current Medicare enrollment. You must be a permanent resident of Michigan to purchase an Alliance Medicare Supplement insurance policy. Please refer to the enclosed *Outline of Coverage* for the monthly cost of the plan and description of what each plan covers.

Your coverage will become effective on the **first day of the month** following receipt and approval of your completed enrollment application. You may also request a later coverage date. Please indicate your choice:

Requested coverage date: ___/___/_____ (MM/DD/YYYY) This will be your first month of coverage.

NEW TO MEDICARE*:

If you turn 65 and become eligible for Medicare on or after 1/1/2020, you are eligible for these plans:

☐ Plan A ☐ Plan D ☐ Plan G ☐ Plan N

If you are younger than 65, and become eligible for Medicare on or after 1/1/2020, you are eligible for these plans: ☐ Plan A ☐ Plan G

ALREADY ENROLLED IN MEDICARE*:

If you will be 65 or older in your first month of Medicare coverage and your first month of coverage began prior to 1/1/2020, you are eligible for these plans:

☐ Plan A ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan G ☐ Plan N

If you are younger than 65, are eligible for Medicare coverage, and your first month of coverage began prior to 1/1/2020, you are eligible for these plans:

☐ Plan A ☐ Plan C

** You must be enrolled in Medicare Parts A and B, and must not have more than one Medicare supplement policy to be eligible for any plan.*

3 Optional Dental and Vision Packages*

Please select the optional package to buy:

☐ **PACKAGE 1**
$52.30 additional monthly premium plan

☐ **PACKAGE 2**
$71.00 additional monthly premium plan

☐ **PACKAGE 3**
$69.90 additional monthly premium plan

☐ OPT OUT of dental and vision coverage

**Network restrictions apply. See enclosed flyer or Outline of Coverage for details.*

Questions? Call (833) 923-1797 (TTY: 711) and talk to our Medicare sales representative.

4 You may qualify for a guaranteed acceptance

	YES	NO
1. Did you turn 65 within the last six months or will you turn 65 within your first month of requested coverage?	☐	☐
If YES, your acceptance is guaranteed. **SKIP TO SECTION 6.**		
2. Did you enroll in Medicare Part B **for the first time** within the last six months?	☐	☐
If YES, your acceptance is guaranteed. **SKIP TO SECTION 6.**		
3. Have you lost other creditable health insurance coverage within the last 63 days, or have you received a notice from your prior insurer that you are losing coverage?	☐	☐
If YES, you **may be** guaranteed acceptance in plan C, D, F or G. **You must provide your loss of coverage notice from your previous insurer.** Please email to: HAPMedicareAgent@hap.org. **SKIP TO SECTION 6.**		
4. Are you currently covered under a Medicare Advantage plan and enrolled in that plan within the first 12 months of getting Medicare Part A? **SKIP TO SECTION 6.**	☐	☐
5. Are you currently covered under a Medicare Advantage plan and are returning to a Health Alliance Plan by Henry Ford Health Medicare Supplement plan within the first 12 months of enrolling in the MA plan? **SKIP TO SECTION 6.**	☐	☐
6. Did your Medicare Part B become effective between March 2020 through April 2023, and have you lost Medicaid coverage in the last 63 days?	☐	☐
If YES, you **may be** guaranteed acceptance in plan C, D, F or G. **You must provide your loss of coverage notice issued by MDHHS.** Please email to: HAPMedicareAgent@hap.org. **SKIP TO SECTION 6.**		

5 Complete this section (Do not complete this section if you qualify for guaranteed acceptance).

The information you provide is confidential and will be used and disclosed only as permitted by our Notice of Privacy Practices, which you can read online at hap.org/privacy

Health Information:

	YES	NO
(a) In the past two years, I have used tobacco in any form	☐	☐
(b) Are you enrolled in Medicare before age 65 due to disability?	☐	☐
If YES, please explain the type of disability and how long you have been covered by Medicare.		
_____		
(c) Please select Yes or No for:		
(1) I have been diagnosed with End Stage Renal (kidney) Disease (ESRD)	☐	☐
(2) I have kidney disease that will require dialysis	☐	☐
(3) I currently receive dialysis	☐	☐
(4) I have been hospitalized overnight in the last 90 days	☐	☐

If "yes", why were you hospitalized, for what condition(s)?_____

(d) Height: _____ feet _____ inches Weight: _____pounds

(e) Have you, due to mental or physical disability, authorized any person or institution to legally act on your behalf and take over your personal business transactions, and if "yes", is that person currently acting on your behalf under a legal Power of Attorney?	☐	☐

If YES, please provide their name and relationship and include a copy of the Financial Power of Attorney, Letter of Conservatorship or other legal documents with this application

Name:_____Relationship: _____

(f) In the past 12 months, have you been told you will need treatment, tests or surgery that has not yet been done?	☐	☐

If YES, please explain:_____

Questions? Call (833) 923-1797 (TTY: 711) and talk to our Medicare sales representative.

5 Health Information *(continued)*

YES NO

(g) In the past 12 months, have you been hospitalized? ☐ ☐

If YES, please explain the date(s) and reason(s) for each hospital stay, and the length of each hospital stay: _____

(h) Do you visit any medical doctors or providers more than monthly for medical advice or treatment? ☐ ☐

If YES, please explain: _____

(i) In the past 2 years, have you been diagnosed with, treated or been advised to be treated for any of the following:

(1) ☐ Cancer (except basal cell skin cancer) ☐ leukemia ☐ lymphoma ☐ melanoma or ☐ other cancer

(2) ☐ Chronic Lung Disease ☐ COPD ☐ emphysema ☐ mesothelioma ☐ cystic or pulmonary fibrosis or any other respiratory disorder

(3) ☐ Cirrhosis of the liver ☐ any liver or pancreas disease ☐ hepatitis C ☐ kidney disease

(4) ☐ Diabetes
Please check all of the following treatments or conditions that also apply:
☐ Insulin use ☐ insulin pump ☐ neuropathy ☐ hypertension ☐ kidney problems ☐ amputation ☐ retinal/eye issues

(5) ☐ Stroke ☐ TIA (transient ischemic attack) ☐ hemophilia ☐ or clotting disorder

(6) ☐ Angina pectoris ☐ heart attack ☐ congestive heart failure ☐ valvular heart disease ☐ any heart disease ☐ atrial fibrillation ☐ have a pacemaker ☐ carotid artery disease ☐ cardiomyopathy ☐ pulmonary hypertension ☐ left bundle branch block or ☐ other heart conditions

(7) ☐ Alzheimer's Disease ☐ Parkinson's Disease ☐ ALS (Lou Gehrig's Disease) ☐ Cerebral Palsy ☐ Muscular Dystrophy ☐ Huntington's Disease ☐ Multiple Sclerosis (MS) ☐ paralysis ☐ quadraplegia ☐ hemiplegia ☐ or other neurological disorder

(8) ☐ Any immune system disorder ☐ AIDS ☐ HIV+ ☐ lupus ☐ rheumatoid arthritis ☐ Crohn's Disease

(9) ☐ Any psychological disorder such as schizophrenia ☐ bipolar disorder ☐ major depression ☐ suicide attempt ☐ substance abuse ☐ or other mental condition requiring outpatient or inpatient treatment

(10) ☐ Any organ ☐ or bone marrow transplant

(11) ☐ Any systemic lupus ☐ joint replacement ☐ or back or spine surgery?

If YES, please explain: _____

(j) Are you taking prescription medications? ☐ **YES** ☐ **NO**

If YES, please list medications and the conditions for which they are taken:

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

Medication: _____ Reason for use: _____

5 Health Information *(continued)*

(k) When was your last doctor visit and your last physical?

Date: ____/____/_____ Reason for visit: _____
MM DD YYYY

Tests performed:_____

Test results or recommendations:_____

	YES	NO
(l) Do you have any other medical conditions not previously mentioned? ..... Please provide details for all "yes" answers. Include diagnosis, treatments, dates and current status.	☐	☐

Question #	Condition/Diagnosis	Treatment	Dates	Current Status

Authorization for the Release of Medical Information

I understand that Alliance Health and Life Insurance Company (Alliance) may need to collect personal information about me from outside sources in order to approve my Alliance Medicare Supplement Application.

I authorize Alliance to review and look at its own records for information needed to process this application.

I authorize any medical professional, doctor, hospital, clinic or other medical facility, government agency or other medical person to disclose information, including copies of records concerning advice, care or treatment provided to me in order for Alliance to review and evaluate this application. This authorization does not permit the disclosure of provider's notes from psychotherapy sessions that are separate from the provider's other medical records.

For purposes of determining my qualification for coverage, this authorization is valid for 24 months from the date of my signature.

I understand that signing this authorization is voluntary. I can refuse to sign this authorization. But if I don't sign the authorization I may not be eligible to enroll in coverage with Alliance.

I understand that my information may be shared with others as part of this authorization and that when the information is shared it may no longer be protected by federal privacy laws.

I can revoke this authorization at any time by sending written notice to:
Health Alliance Plan by Henry Ford Health Customer Service; 1414 E. Maple Road, Troy, MI 48083. I understand that revocation will not affect any action taken in reliance on this authorization before Alliance gets my notice to revoke.

5 Health Information *(continued)*

If you are signing as the authorized personal representative you must provide this information and enclose or attach a copy of the appropriate legal documentation.

Applicant Signature

X _____ DATE (REQUIRED) ____/____/_____
YOUR SIGNATURE (REQUIRED) MM DD YYYY

PERSONAL REPRESENTATIVE NAME
(if legal Power of Attorney is enacted) _____

X _____ DATE (REQUIRED) ____/____/_____
PERSONAL REPRESENTATIVE SIGNATURE (REQUIRED) MM DD YYYY

ADDRESS _____

PHONE (_____) _____ – _____ RELATIONSHIP TO APPLICANT_____

6 For your protection, you are required to read the statements below and answer all the questions on the next page.

Please read these statements

- 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.
- If you are 65 or older you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If you are eligible for Medicaid at any age, you 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 may be suspended during your entitlement to benefits under Medicaid for 24 months at your request. 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 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.
- 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 have guaranteed issue rights in one or more of our Medicare supplement plans.

6 For your protection, you are required to read the statements below and answer all the questions. *(continued)*

Please answer all these questions to the best of your knowledge. Clearly mark the correct answer.

	YES	NO
(1) Are you covered for medical assistance through the state Medicaid program? (Note: 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) Do you have an active Medicare supplement policy?	☐	☐

If YES, with what company, and what plan do you have?

_____

(b) If YES, do you intend to replace your current Medicare supplement policy with this policy?	☐	☐
(3) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	☐	☐

(a) If YES, with what company and what kind of policy?

_____

(b) What are your dates of coverage under the other policy?

START (MM DD YYYY) ____/ ___/_____ END (MM DD YYYY) ____/ ___/_____

(If you are still covered under this policy, leave "END" blank.)

7 Household Discount

	YES	NO
Is an existing member of your household also applying for a Health Alliance Plan by Henry Ford Health Medicare Supplement Plan?	☐	☐
Does an existing member of your household have an active Health Alliance Plan by Henry Ford Health Medicare Supplement Plan?	☐	☐

If YES to one or both questions, please list member name and Member ID#.

Health Alliance Plan by Henry Ford Health
Medicare Supplement Member Name: _____

Member ID#_____

Household members may be eligible for a discount when they both are enrolled in a Health Alliance Plan by Henry Ford Health Medicare Supplement Plan.

The discount becomes effective either on the enrollment date if indicated on this application, or the first of the month following receipt of notification about the household member. Discounts will not be applied retroactively.

8 Billing and Premium Payment Information

You will automatically receive an invoice for your monthly plan premium*.

You can pay by one of the following:

1. Pay by mail.
2. Make an online payment or set up Automatic Withdrawal.

   You can pay your monthly plan premium using **Pay My Bill,** an easy, secure online payment option. Register at **www.hap.org/login** and click "Pay My Bill" where you can view your invoice and choose your payment method.

   - Make a one-time payment
   - Credit or Debit card
   - Set up auto pay (monthly payments) using checking or savings account or credit card

**Failure to pay the total premium on either medical or dental/vision package will result in termination of the entire policy. You must pay your plan premiums to continue being a member of our plan.*

We do not accept premium payment from third parties. We will, however, accept payment of your premium from your spouse, or when appropriate, from a parent, legal guardian, agent or other person or entity that is specifically allowed by law to pay premiums on your behalf.

If payment for coverage is made by a **third party** other than the primary applicant, the following shall all result:

1. The primary applicant shall remain financially responsible for payment if an account transfer or credit card is declined.
2. By making payment, the third party shall have no formal rights recognized by Health Alliance Plan by Henry Ford Health concerning coverage.
3. Any legal refund or adjustment of premiums or other financial settlement will be delivered to the primary applicant and not to the third party.

How to submit this application*

- Online at **hap.org/medicare**
- Email to: **hapmedicareagent@hap.org**
- Applicants may also mail in applications at:

Health Alliance Plan by Henry Ford Health
Attention: Medicare Sales
1414 E. Maple Road
Troy, MI 48083

Agents must submit applications online at **hap.org/medicare or email to **hapmedicareagent@hap.org***

9 This section is very important. Your application will not be processed unless you sign and date below.

- My signature below indicates that I have read and understand the contents of this application.
- I acknowledge receipt of the Alliance Medicare Supplement *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.
- Prior to canceling any other coverage, please make sure policy has been approved.
- You will receive a Medigap Policy Booklet confirming your coverage date. We will accept an application 90 days in advance of the effective date.

If I choose to cancel my coverage after the first 30 days, I understand I must write or call HAP Customer Service department.

If you are signing as the authorized personal representative you must provide this information and enclose or attach a copy of the appropriate legal documentation.

Applicant Signature

X _____ DATE (REQUIRED) ____/____/_____
YOUR SIGNATURE (REQUIRED) MM DD YYYY

PERSONAL REPRESENTATIVE NAME
(if legal Power of Attorney is enacted) _____

X _____ DATE (REQUIRED) ____/____/_____
PERSONAL REPRESENTATIVE SIGNATURE (REQUIRED) MM DD YYYY

ADDRESS _____

PHONE (_____) _____ – _____ RELATIONSHIP TO APPLICANT_____

∗ *If you have authorized any person or institution to legally act on your behalf and take over your personal business transactions, please provide their name and relationship and include a copy of the Financial Power of Attorney, Letter of Conservatorship or other legal documents with this application.*

10 For agent/broker use only

	YES	NO
1. Have you sold any other health plan policies to this individual that are still in force?	☐	☐
If YES, policy description(s): _____		
2. Have you sold any health plan policies to this individual in the last five (5) years that are not still in force?	☐	☐
If YES, policy description(s): _____		
3. I asked the applicant all the questions in this application and the answers are recorded as given to me.	☐	☐

AGENT NAME (REQUIRED)

NATIONAL PRODUCER NUMBER (REQUIRED)

AGENT/NATIONAL PRODUCER SIGNATURE (REQUIRED)

DATE (REQUIRED) ____/____/_____
MM DD YYYY

Health Alliance Plan®
by Henry Ford Health

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