

**ENROLLMENT APPLICATION  
FOR UNITY HEALTH PLANS INSURANCE CORPORATION**

You must be enrolled in Medicare Parts A and B to enroll.

**1. Information About You**

Please type or print firmly and clearly - DO NOT COMPLETE SHADED AREAS

Applicant-Last Name:		First Name:			Middle Initial:
Street Address:	Apt. #:	City:	State:	Zip Code:	County:
Do you live at this address year-around? <input type="checkbox"/> Yes <input type="checkbox"/> No    If no, please explain:					
Home Telephone: (    )	Birth date:		Gender: <input type="checkbox"/> M <input type="checkbox"/> F	For Unity Use Only:	
Primary Care Physician or Clinic:	Address:			Provider Number:	
Do you use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No					
For Unity Use:    Approved <input type="checkbox"/>		Date:		Underwriter:	
Denied <input type="checkbox"/>					

**2. Premium Payment**

Please include premium payment for one month or one quarter (choose one below) with your application.

- Monthly premium of \$\_\_\_\_\_ included.                       Quarterly premium of \$\_\_\_\_\_ included.  
 Semi-Annual premium of \$\_\_\_\_\_ included.                       Annual Premium of \$\_\_\_\_\_ included.

Effective date requested (mo/day/yr):    /    /

Electronic Funds Transfer (EFT) service allows us to automatically transfer funds from your checking or savings account for your monthly premium payment. Once your request is processed, we will withdraw funds from your account on the first of each month for that month of coverage.

To enroll, please complete the following:

Account Type:  Checking     Savings

- If Checking, attach a voided check.
- If Savings, please provide Account Number \_\_\_\_\_ and ABA Transit Number (contact financial institution for this number) \_\_\_\_\_

Financial Institution Name: \_\_\_\_\_

Financial Institution Address: \_\_\_\_\_

I (we) hereby authorize Unity Health Insurance to initiate debit entries to my (our) personal account (indicated above) at the named financial institution.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Spouse's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### 3. Information About Other Insurance Coverage You May Have

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 our Medicare Select plan. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS BELOW:

Please mark YES or NO below with an "X."

To the best of your knowledge,

- 1. a. Did you turn age 65 in the last 6 months? .....  Yes  No
- b. Did you enroll in Medicare Part B in the last 6 months?.....  Yes  No
- c. If yes, what is the effective date? \_\_\_\_/\_\_\_\_/\_\_\_\_

- 2. Are you covered for medical assistance through the state Medicaid program: .....  Yes  No

**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 you answered YES to this question,

- a. Will Medicaid pay your premiums for this Medicare Select policy? .....  Yes  No
- b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? .....  Yes  No

- 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 preferred provider plan), 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 Select policy?.....  Yes  No
- c. Was this your first time in this type of Medicare plan?.....  Yes  No
- d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?.....  Yes  No

- 4. a. Do you have another Medicare Supplement policy in force?.....  Yes  No
- 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? ..  Yes  No

- 5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? .....  Yes  No

- a. If so, with what company and what kind of policy? \_\_\_\_\_

- b. What are your dates of coverage under the other policy? (Leave END blank if you are still covered under the other policy.)

START \_\_\_\_/\_\_\_\_/\_\_\_\_                      END \_\_\_\_/\_\_\_\_/\_\_\_\_

- 6. Are you currently covered by another Unity Health Insurance policy? .....  Yes  No
- If yes, please provide your Unity Member Number: \_\_\_\_\_

You must be enrolled in Federal Medicare Parts A and B to qualify for this policy. Please provide a copy of your Medicare Identification Card and complete the following:

Medicare Hospital Insurance (Part A) Effective Date (Mo/Day/Yr): \_\_\_\_\_

Medicare Medical Insurance (Part B) Effective Date (Mo/Day/Yr): \_\_\_\_\_

Medicare Prescription Drug Insurance (Part D) Effective Date (Mo/Day/Yr): \_\_\_\_\_

Federal Medicare Identification Number: \_\_\_\_\_

#### 4. Health Questionnaire

**NOTE: If you are applying within 6 months of enrolling in Medicare Part B OR within 6 months of turning 65 if you were enrolled in Medicare before turning 65 OR if you are applying under guaranteed issue, do not complete this section.**

Height:	Weight:
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Please answer the following questions. If you answer “yes” to any, you are not eligible for Unity Health Insurance Medicare Select coverage.

A. Are you currently hospitalized, bedridden, confined to a wheelchair or skilled nursing facility?  Yes  No

B. Within the past year, have you:

1. been scheduled to have surgery for any condition, but not had such surgery?.....  Yes  No

2. been diagnosed or treated for internal cancer or malignant melanoma? .....  Yes  No

3. received Medicare-approved home health care more than once? .....  Yes  No

C. Within the past two (2) years, have you:

1. been diagnosed or treated for:

a. heart valve surgery? .....  Yes  No

b. Alzheimer’s disease, organic brain syndrome or senility? .....  Yes  No

c. cirrhosis of the liver? .....  Yes  No

d. alcoholism or drug addiction?.....  Yes  No

2. had any type of amputation caused by disease? .....  Yes  No

3. had kidney failure or been advised to have kidney dialysis?.....  Yes  No

4. had a stroke or seizure disorder?.....  Yes  No

5. been treated for, or diagnosed with, diabetes requiring insulin? .....  Yes  No

6. been treated for a chronic lung disorder requiring oxygen therapy? .....  Yes  No

D. Have you had a heart, lung, liver or pancreas transplant or been told you may need a transplant operation in the future because of a current chronic health condition? .....  Yes  No

#### 5. Signature And Consent To Release Medical Information

By signing this application below, I understand and agree that:

- A. All statements and answers I have given are complete and true to the best of my knowledge and belief. I understand that any material misstatement in this health questionnaire may result in the denial of claims and/or rescission of coverage.
- B. The insurance I hereby apply for will be effective only when Unity Health Insurance approves this application. Evidence of such approval will be issuance of the policy. The effective date will be the date shown on the ID card issued.
- C. I hereby acknowledge that I have received a copy of the Outline of Coverage for Unity Health Insurance Medicare Select Policy and a copy of the brochure published by the Wisconsin Office of the Commissioner of Insurance entitled "Wisconsin Guide to Health Insurance for People with Medicare" on the date stated below.
- D. I authorize any health care provider, including physicians, clinics, hospitals or other institutions named in the application for insurance or who attends or has attended me, at any time, to disclose to Unity Health Insurance information from my health care record. I understand this could include, but is not limited to, my identity, medical history, diagnosis, prognosis, date of treatment, treatment test results and summary reports. This disclosure is without limitation to period of treatment, diagnostic or therapeutic information, history or type of illness including treatment, if any, for alcohol and drug abuse. This disclosure is being made so that Unity Health Insurance can evaluate my application for health insurance, and/or to facilitate on-going Quality Assurance and Medical Management programs conducted by Unity Health Insurance. I also understand that this consent is revocable except to the extent that action has been taken in reliance upon it, and that consent will remain in force for two and one-half years in order to effectuate the purposes for which it is given. A photocopy of this authorization is as valid as the original.
- E. I hereby make application for the Unity Health Insurance Medicare Select Policy. I understand that if my application is accepted, I will not be covered for health conditions which pre-exist coverage under this policy until this policy has been in effect for six consecutive months unless the waiting period is reduced by a continuous period of creditable coverage.
- F. This policy will not cover medical expenses incurred prior to its effective date. However, benefits are payable under this policy for any condition covered by any other Unity Health Insurance policy in effect prior to the effective date of this policy if coverage is continuous and without a lapse of more than 63 days.

I have considered all the above factors, and I believe that this policy suits my needs. I authorize Unity Health Insurance or other holder of medical or related information to release to the Centers for Medicare and Medicaid Services, or its intermediaries or carriers, any information necessary to administer Title XVIII of the Social Security Act.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE REVIEW BEFORE YOU MAIL**

1. Be sure to complete all sections of the application (except the shaded areas).
2. Be sure to complete the health questionnaire. (If you are applying for coverage during an open enrollment period, do **NOT** submit the health questionnaire with your application. Please refer to “The Time to Enroll” section on page 1 in the Outline of Medicare Supplement Insurance you received with this enrollment application.)
3. Be sure to sign and date the application.
4. Please select a Primary Care Physician or Clinic from our list of Primary Care Physicians and Clinics. Participating physicians and providers are listed in the Unity Provider Directory.
5. If you are canceling other coverage, be sure to fill out the replacement form. DO NOT cancel the coverage until you have actually received a Unity policy and you are sure you want to keep it.
6. Be sure you have supplied a copy of your Medicare Identification Card, your Medicare Card number and effective dates.



Unity Health Plans Insurance Corporation  
840 Carolina Street  
Sauk City, Wisconsin 53583-1374  
608-643-2491 or 1-800-362-3308

## MEDICARE NOTICE

**SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.**

### MEDICAL ASSISTANCE ENTITLEMENT NOTICE

1. You do not need more than one Medicare Supplement, Cost or Select 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 or Medicare Select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Select policy can be suspended, if requested, 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 policy will be reinstated upon your request within 90 days of losing Medicaid eligibility. If your previous policy is no longer available, you will be offered a substantially equivalent policy. If your previous Medicare Supplement or Select 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 suspension.
5. If you are eligible for and have enrolled in a Medicare Supplement, Cost or Select 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, Cost or Select 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, Cost or Select policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement, Cost or Select policy will be reinstated, or if it is no longer available, a substantially equivalent policy will be issued if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement, Cost or Select 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 suspension.
6. Counseling services are available in Wisconsin to provide advice concerning your purchase of Medicare Supplement or Select coverage 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). See the booklet "Wisconsin Guide to Health Insurance for People with Medicare" that you received at the time you were solicited to purchase this policy.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE**

According to information you have furnished, you intend to terminate existing Medicare supplement, Medicare cost, Medicare Select or Medicare Advantage insurance and replace it with a policy to be issued by Unity Health Plans Insurance Corporation. Your new policy will provide 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 the purchase of this Medicare Select coverage is a wise decision, you should terminate your present Medicare supplement, Medicare cost, Medicare select 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, AGENT, BROKER OR OTHER REPRESENTATIVE**

I reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Select policy will not duplicate your existing Medicare supplement, Medicare cost, Medicare select or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, cost, select or leave you Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has prescription drug coverage and I am enrolling in Medicare Part D.
- Disenrollment from a Medicare Advantage Plan. (Please explain reason for disenrollment.)

\_\_\_\_\_  
\_\_\_\_\_

- Other (Please specify.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

1. Note: Health conditions that 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 condition waiting periods. Unity Health Insurance will waive any time periods applicable to pre-existing condition

waiting periods in the new policy for similar benefits to the extent such time was satisfied under the Medicare supplement 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 requested 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 requested information has been properly reported. (If your policy is guaranteed issue (not health underwritten), this paragraph does not apply.

***Do not cancel your present policy until you have received your new policy and are sure you want to keep it!***

I acknowledge that I received and understand the following information from Unity Health Insurance: Outline of Coverage, Directory of Unity Health Insurance HMO Providers, and “Wisconsin Guide to Health Insurance for People with Medicare” published by the Office of the Commissioner of Insurance.

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Signature of Agent, Broker or Other Representative  
(Not required for direct response sales)

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(Applicant’s Signature)

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(Date)