



Medicare Supplement Coverage Options

Thank you for your interest in our Medicare Supplemental coverage options, also known as HealthNow (Medigap) policies. The Medicare Supplement Plans, when combined with payments made by Medicare, are designed to reduce your out-of-pocket costs for most Medicare-covered services. We offer three Medicare Supplemental policies – you choose the benefit design that best meets your needs.

Why Do I Need a Medicare Supplemental (Medigap) Policy?

A Medicare Supplemental policy provides coverage for health care expenses that Medicare does not cover. These policies pay most, if not all, of the Original Medicare Plan coinsurance and outpatient copayment amounts. Some policies also cover the Original Medicare Plan deductibles. Please refer to the enclosed “*Outline of Medicare Supplemental Coverage Benefit Plans*” for details about the benefits of each plan.

Your cost-sharing is nominal and with some plans, there is none at all. There is no need for you to get referrals and there are no networks. Plan members can receive medical care from any doctor, specialist, or hospital that participates with Medicare.

How to Enroll

Enrolling is simple. To enroll in a HealthNow Medicare Supplemental policy, complete and return your application to us in the enclosed envelope. Do not include payment at this time. We will process your application and bill you at a later date.

You will also promptly receive a policy and identification card. If you are not completely satisfied, return the policy and membership card within 30 days from the day you received the card. Any premium payments you have made will be refunded in full. In the event you have filed a claim within this 30-day period, you will be responsible for the cost of any services you received.

Questions?

Please call our Government Programs Sales Department at 1-800-700-8482 if you have any questions. You may also contact us using the *Click & Comment* feature of our web site at www.healthnowny.com. If you are a current member you may call our Customer Service Department at 1-800-329-2792.

For more information about Medicare coverage and Medigap policies, you may want to review the “*Guide To Health Insurance For People With Medicare.*” You may obtain this guide from your local Social Security office, or from the Medicare web site at www.medicare.gov.



Outline of Medicare Supplement Coverage Benefit Plans A, B, and C.

Medicare Supplement insurance can be sold in only 12 standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plans "A" and "B". The plans we sell are A, B, and C.

- BASIC BENEFITS:** Included in all plans.
- Hospitalization: Part A coinsurance plus coverage for 365 additional days in your lifetime after Medicare benefits end.
- Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or in the case of hospital outpatient department services under a prospective payment system, applicable copayments.
- Blood: First three pints of blood each year.

A	B	C	D	E	F / F*	G	H	I	J / J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
				Preventive Care Not Covered by Medicare					Preventive Care Not Covered by Medicare

Outline of Medicare Supplement Coverage

Basic Benefits for Plans K and L include similar services as Plans A – J, but cost-sharing for the basic benefits is at different levels.

	K**	L**
Basic Benefits:	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End	100% of Part A Hospitalization Coinsurance plus coverage for 365 Days after Medicare Benefits End
	50% Hospital cost-sharing	75% Hospital cost-sharing
	50% of Medicare-eligible expenses for the first three pints of blood	75% of Medicare-eligible expenses for the first three pints of blood
	50% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services	75% Part B Coinsurance, except 100% Coinsurance for Part B Preventive Services
Skilled Nursing Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care <i>not</i> Covered by Medicare		
	\$4000 Out of Pocket Annual Limit***	\$2000 Out of Pocket Annual Limit***

** Plans K and L provide for different cost-sharing for items and services than Plans A – J. Once you reach the annual limit, the plan plays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does **not** include charges from your provider that exceed Medicare-approved amounts, called “Excess Charges”. You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase each year for inflation.

*Plans "F" and "J" also have an option called a high deductible Plan "F" and a high deductible Plan "J". These high deductible plans pay the same or offer the same benefits as Plans "F" and "J" after one has paid a calendar year \$1,730 deductible. Benefits from high deductible Plans "F" and "J" will not begin until out-of-pocket expenses are \$1,730. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include, in Plans "F" and "J", the plan's separate foreign travel emergency deductible. (The calendar year high deductible for high deductible plans "F" and "J" shall be adjusted annually thereafter by the Secretary of the United States Department of Health and Human Services.)

PREMIUM INFORMATION

HealthNow New York Inc. can only raise your premium if we raise the premium for all policies like yours in this state.

**REGION II
Dutchess, Orange, Putnam, Sullivan, Ulster**

PLAN TYPE	MONTHLY PREMIUM	QUARTERLY PREMIUM	SEMI-ANNUAL PREMIUM	ANNUAL PREMIUM
Plan A	\$178.16	\$534.48	\$1,068.96	\$2,137.92
Plan B	\$212.77	\$638.31	\$1,276.62	\$2,553.24
Plan C	\$251.00	\$753.00	\$1,506.00	\$3,012.00

Rates effective 02/01/2010

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to HealthNow New York Inc., Government Programs, PO Box 13599, Albany, New York 12214-5767. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs. Neither HealthNow New York Inc., nor its agents are connected with Medicare.

This **Outline of Coverage** does not give all the details of Medicare coverage. Contact your local Social Security office or consult "*Medicare and You*" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

PLAN A

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

This policy meets or exceeds the minimum standards for Medicare Supplement Insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 85 percent. This ratio is the portion of future premiums which the company expects to return as benefits when averaged over all people with this policy.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$0 \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$1100 (Part A deductible) \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PLAN A

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN A PAYS	WITH PLAN A YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (Above Medicare-approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$155 (Part B deductible) \$0 All costs
BLOOD First three pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B deductible) \$0
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PLAN B

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

This policy meets or exceeds the minimum standards for Medicare Supplement Insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 85 percent. This ratio is the portion of future premiums which the company expects to return as benefits when averaged over all people with this policy.

SERVICES	MEDICARE PAYS	PLAN B PAYS	WITH PLAN B YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 \$0 \$0	\$0 Up to \$137.50 a day All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PLAN B

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN B PAYS	WITH PLAN B YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (Above Medicare-approved amounts)	\$0 Generally 80% \$0	\$0 Generally 20% \$0	\$155 (Part B deductible) \$0 All costs
BLOOD First three pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$0 20%	\$0 \$155 (Part B deductible) \$0
CLINICAL LABORATORY SERVICES BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$0 20%	\$0 \$155 (Part B deductible) \$0
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PLAN C

MEDICARE (PART A) HOSPITAL SERVICES PER BENEFIT PERIOD

This policy meets or exceeds the minimum standards for Medicare Supplement Insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 85 percent. This ratio is the portion of future premiums which the company expects to return as benefits when averaged over all people with this policy.

SERVICES	MEDICARE PAYS	PLAN C PAYS	WITH PLAN C YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing, and miscellaneous services and supplies First 60 days 61 st thru 90 th day 91 st day and after: While using 60 Lifetime Reserve days Once Lifetime Reserve days are used: - Additional 365 days (lifetime) - Beyond the additional 365 days	All but \$1100 All but \$275 a day All but \$550 a day \$0 \$0	\$1100 (Part A deductible) \$275 a day \$550 a day 100% of Medicare-eligible expenses \$0	\$0 \$0 \$0 \$0 All costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital First 20 days 21 st thru 100 th day 101 st day and after	All approved amounts All but \$137.50 a day \$0	\$0 Up to \$137.50 a day \$0	\$0 \$0 All costs
BLOOD (per calendar year) First three pints Additional amounts	\$0 100%	Three pints \$0	\$0 \$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	\$0	Balance

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

PLAN C

MEDICARE (PART B) MEDICAL SERVICES PER CALENDAR YEAR

* Once you have been billed \$155 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN C PAYS	WITH PLAN C YOU PAY
MEDICAL EXPENSES IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts Part B excess charges (Above Medicare-approved amounts)	\$0 Generally 80% \$0	\$155 (Part B deductible) Generally 20% \$0	\$0 \$0 All costs
BLOOD First three pints Next \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	\$0 \$0 80%	All costs \$155 (Part B deductible) 20%	\$0 \$0 \$0
CLINICAL LABORATORY SERVICES BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	\$0	\$0

MEDICARE PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable medical equipment First \$155 of Medicare-approved amounts* Remainder of Medicare-approved amounts	100% \$0 80%	\$0 \$155 (Part B deductible) 20%	\$0 \$0
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OTHER BENEFITS NOT COVERED BY MEDICARE

FOREIGN TRAVEL - NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First \$250 each calendar year Remainder of charges	\$0 \$0	\$0 80% to a lifetime Maximum Benefit of \$50,000	\$250 20% and amounts over the \$50,000 lifetime maximum
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Application for
Medicare Supplement Insurance
(Plan A, Plan B, or Plan C)

The sale of a Medicare Supplement policy is prohibited where an individual has a Medicare Supplement policy in force and does not desire to replace the existing policy or where the Medicare Supplement policy would duplicate benefits to which the individual is entitled under a Medicare Advantage Plan.

The Medicare Supplement policy you are applying for contains a pre-existing condition limitation. A pre-existing condition is a condition (whether physical or mental), regardless of the cause of the condition, for which you received medical advice, diagnosis, or treatment within six (6) months prior to the date you became covered under the Medicare Supplement policy. We will not pay for any expense, for any service or care in connection with such a pre-existing condition until you have been continuously enrolled under the Medicare Supplement policy for at least six (6) consecutive months.



HealthNow New York Inc.
PO Box 15033
Albany, New York 12212-5033
1-800-700-8482



Medicare Supplemental Membership Application

PO Box 13599, Albany, New York 12214-5767

Check One: New Enrollment Change

Please review this entire application and complete all sections which apply to you, including questions on reverse side. Please print in ink.

Last Name	First	Initial	Social Security Number
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Street Address

City	State	Zip Code
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Telephone Number (include area code)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
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Change – If this is a change to Medicare Supplemental coverage, please give reason:

Reason _____

_____ **Date** _____

I am applying for: (Check One)	<input type="checkbox"/> Medicare Supplemental "A"	Payment Selection (check one)
<input type="checkbox"/> Medicare Supplemental "B"	<input type="checkbox"/> Medicare Supplemental "C"	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly

Provide Medicare Information as it appears on Medicare Identification Card.

Medicare Claim No. and Letter: _____

Hospital – Part A Effective Date _____

Medical – Part B Effective Date _____

Prescription – Part D Effective Date _____

1. You do not need more than one Medicare Supplement policy or certificate.
2. If you purchase this policy (certificate), you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy (certificate).
4. The benefits and premiums under your Medicare Supplement policy (certificate) may 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 (certificate) will be reinstated if requested within 90 days of losing Medicaid eligibility.)
5. 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).

Important Notice

"Any person who knowingly and with intent to defraud any insurance company of 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, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature: _____ Date: _____

Group Number	Effective Date	Hospital	Medical	Received

Miscellaneous Enrollment Information

If you need help in completing this application, please call our Sales Department at 1-800-248-9296 from 8:30 a.m. to 5:00 p.m. Monday through Friday.

Please answer completely and to the best of your knowledge and belief.

Please mark "Yes" or "No" with an "X".

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

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 yes,

- a. Will Medicaid pay your premiums for this Medicare supplement policy? Yes No
b. Do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? Yes No

3. If you had coverage from any Medicare Advantage plan other than original Medicare within the past 64 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave **end date** blank.

Start Date: _____ End Date: _____

- a. If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare supplement policy? Yes No
b. Was this your first time in this type of Medicare Advantage plan? Yes No
c. Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan? Yes No
4. a. Do you have another Medicare supplement or Medicare Select policy or certificate in force? Yes No

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

Company: _____ Plan: _____

- b. Identification Number: _____
c. If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy or certificate? Yes No

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

- a. If so, with which company? _____
b. What type of policy? _____
c. Identification Number: _____
d. What are your dates of coverage under the other policy?

Start Date: _____ End Date: _____

If you are still covered under the other policy, leave **end date** blank.



Medicare Supplemental Membership Application

PO Box 13599, Albany, New York 12214-5767

Check One: New Enrollment Change

Please review this entire application and complete all sections which apply to you, including questions on reverse side. Please print in ink.

Last Name	First	Initial	Social Security Number
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Street Address

City	State	Zip Code
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Telephone Number (include area code)	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
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Change – If this is a change to Medicare Supplemental coverage, please give reason:
Reason _____

Date _____

I am applying for: (Check One)	<input type="checkbox"/> Medicare Supplemental "A"	Payment Selection (check one)
<input type="checkbox"/> Medicare Supplemental "B"	<input type="checkbox"/> Medicare Supplemental "C"	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly

Provide Medicare Information as it appears on Medicare Identification Card.

Medicare Claim No. and Letter: _____
Hospital – Part A Effective Date _____
Medical – Part B Effective Date _____
Prescription – Part D Effective Date _____

1. You do not need more than one Medicare Supplement policy or certificate.
2. If you purchase this policy (certificate), you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy (certificate).
4. The benefits and premiums under your Medicare Supplement policy (certificate) may 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 (certificate) will be reinstated if requested within 90 days of losing Medicaid eligibility.)
5. 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).

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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.

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c. Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan? Yes No
4. a. Do you have another Medicare supplement or Medicare Select policy or certificate in force? Yes No

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

Company: _____ Plan: _____

- b. Identification Number: _____
c. If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy or certificate? Yes No

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

- a. If so, with which company? _____
b. What type of policy? _____
c. Identification Number: _____
d. What are your dates of coverage under the other policy?

Start Date: _____ End Date: _____

If you are still covered under the other policy, leave **end date** blank.