FirstCommunity
HEALTH PLAN, INC.

FirstCommunity Senior Select
ENROLLMENT APPLICATION
For Attained Age Medicare Supplement

This application is for effective dates on or after January 1, 2020.

INSTRUCTIONS

- Please print with a ballpoint pen.
- Press hard for good copies.
- Be sure the enrollment form is completed in full so the request for coverage will not be delayed.
- Be sure to sign and date the enrollment form.

APPLICATION CHECKLIST

- ☐ Verify that information on Medicare Card shows Part A and Part B with corresponding effective dates
- ☐ Application is signed in all necessary places
- ☐ Check for first month's premium
- ☐ Bank authorization and void check for each subscriber choosing automatic premium payment
- ☐ Plan type
- ☐ Effective date

IMPORTANT INFORMATION

1. You do not need more than one Medicare supplement 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 policy.
4. 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 24 months. 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 the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. 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).

   I understand that I must receive all medical services from a FirstCommunity Senior Select Participating Hospital to obtain maximum benefits and that coverage of the Part A deductible and coinsurance is limited to FirstCommunity Senior Select Participating Hospitals, except for emergency care or urgently needed care and for services not available through the Participating Hospitals.

QUESTIONS?

If you have questions or need assistance in completing this enrollment application, please call FirstCommunity Senior Select at 256-532-2783 or 1-800-734-7826.

FirstCommunity HEALTH PLAN, INC.
P.O. Box 2887
Huntsville, Alabama 35804-2887
256-532-2783 or 800-734-7826

Effective Date:	Plan Type:

FirstCommunity Senior Select Attained Age Enrollment Application

This application is for effective dates on or after January 1, 2020.

INSTRUCTIONS: Please print clearly and answer ALL questions on this form.

A. Applicant Information

Name (Last, First, Middle Initial)	Social Security No.	Sex	Birth Date
	| |	☐ M ☐ F	Month Day Year

Address (Number and Street Name)	City

State	Zip Code	County	Email Address

Home Phone	Daytime Phone	Emergency Contact Name	Relationship	Emergency Phone No.
( )	( )			

B. Medicare Coverage

You must have Medicare hospital coverage (Part A) and medical coverage (Part B) to enroll. Please copy information from your Medicare card here. →

MEDICARE HEALTH INSURANCE ACT
SOCIAL SECURITY ACT

CLAIM NUMBER
_____

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE (PART A)	___|___|___
MEDICAL INSURANCE (PART B)	___|___|___

C. Medical Questions

If you have enrolled in Medicare Part B for the first time within the last six months, you do not need to answer these medical questions.

1. Have you ever had or been advised to have any organ transplant? ☐ Yes ☐ No If yes, for what?

   _____

2. Currently, are you applying for or using dialysis for kidney disease? ☐ Yes ☐ No

3. Are you currently hospitalized, confined to a skilled nursing facility, or have you been advised that you will require confinement in a skilled nursing facility in the next 30 days? ☐ Yes ☐ No

4. If within the past two years, you have been diagnosed, treated or had any of the following conditions, mark the box next to it. If you are unsure how to respond, please consult your physician.

   Cancer (other than skin cancer) ☐ Yes ☐ No
   Lymphoma ☐ Yes ☐ No
   Melanoma ☐ Yes ☐ No

D. To The Best of Your Knowledge

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. Please mark yes or no below 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
   c. If Yes, what is the effective date? ___|___|___

2. 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.] ☐ Yes ☐ No
   a. If Yes, 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. a. If you had coverage from any Medicare plan OTHER THAN original Medicare within the past 63 days (i.e., 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 ___|___|___ Name of Plan_____

D. To The Best of Your Knowledge (continued)

b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement 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? (If you are still covered under the other policy, leave "END" blank.)
Start ____|____|____ End ____|____|____

E. Check The Plan And Payment Type of Your Choice.

Please Note: *For Automatic Premium Payment (Bankdraft) complete the bank authorization form and include a blank, voided check with your application.*

Plan	**Payment Method**
☐ Plan A ☐ Plan B ☐ Plan G	☐ Automatic Premium Payment (BankDraft) ☐ Monthly Coupon Book

Amount $_____ Check Number_____

F. NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENTAL INSURANCE OR MEDICARE ADVANTAGE:

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

According to information you have furnished, you intend to terminate your existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by FirstCommunity Health Plan. 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 coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement 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 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)**:

☐ Additional benefits.

☐ No change in benefits, but lower premiums.

☐ Fewer benefits, lower premiums.

☐ 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).

☐ Other (please specify)._____

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 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.

F. NOTICE TO APPLICANT (continued)

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

X_____ _____

(Signature of Agent, Broker or Other Representative, if applicable) (Printed Name and Address of Agent, Broker or Other Representative)

The above "Notice to Applicant" was delivered to me on:

Signature of Applicant X_____ Date _____

G. How did you hear about FirstCommunity Senior Select Medicare Supplement?

❑ TV Commercial ❑ Newspaper Ad ❑ Internet Search ❑ Word of Mouth ❑ Insurance Agent

H. Acknowledgment of Receipt of Outline of Coverage

☐ My signature on the line below is to acknowledge receipt of the FirstCommunity Senior Select Outline of Coverage, which describes the benefits for which I applied and how these benefits correlate with Medicare benefits.

I. Acknowledgment of Receipt of the Medicare Buyers Guide

☐ My signature on the line below is to acknowledge receipt of the Guide to Health Insurance for People with Medicare.

J. IMPORTANT INFORMATION

Please read carefully, the IMPORTANT INFORMATION on this form. I hereby acknowledge that I have read the IMPORTANT INFORMATION on this form and declare that all answers to the questions are true and complete. I authorize those providing services to me to release relevant information or medical records to FirstCommunity Health Plan. I understand that all information in these records may be released including that which relates to psychiatric illness, alcohol and drug abuse, HIV testing, AIDS, and infectious disease. I understand that those who provide services to me under FirstCommunity Health Plan are not representatives, agents or employees of the Plan. I am currently covered under Medicare Parts A & B and hereby apply for a FirstCommunity Senior Select policy. I understand the policy is not in force until issue. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in a application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.

X_____ _____

Applicant's Signature Date

X_____ _____

Agent's Name Date

_____

Agent's Address

K. AGENT'S CERTIFICATION

TO BE COMPLETED BY AGENT (ATTACH SEPARATE SHEET, IF NECESSARY)

1. List any other health insurance policy you have sold to the Applicant that is still in force.

_____

2. List any other health insurance policy you have sold to the Applicant in the past five (5) years that is no longer in force.

_____

I certify that:

1. I have truly and accurately recorded on the application the information supplied by the Applicant; and
2. The application was provided to the applicant to review and the applicant has been advised that any false statement or misrepresention in the application may result in loss of coverage under the policy.
3. I have provided an Outline of Coverage of the policy applied for and a Guide to Health Insurance for People with Medicare to the Applicant, prior to completing the application.

X_____ _____

Agent's Signature Date

_____ _____ _____

Agent's Printed Name Agent's No. Agent's Telephone Number