Health First Insurance

6450 US Highway 1, Rockledge, FL 32955

Customer Service: 321.434.4822 • Toll-free 1.855.443.4735 • TTY relay 1.800.955.8771
Monday through Friday from 8 am to 8 pm, Saturday from 8 am to noon

Health First Insurance, Inc. Medicare Supplement Application 2013

A. General Information

First name _____ MI _____ Last name _____ Suffix _____

Social security number _____ Date of birth _____(MM) / _____(DD) / _____ (YYYY)

Gender: Male _____ Female _____ Email _____

Residence address *(PO Box is not allowed)* _____

City _____ State _____ Zip _____ County _____

Mailing address (if different) _____

City _____ State _____ Zip _____ County _____

Home phone (_____) _____ Mobile phone (_____) _____

Have you used tobacco in any form in the past 12 months? ..... Yes No
If you are applying to have coverage effective under age 65, do you have End Stage Renal Disease? ..... Yes No
If you are applying to have coverage effective under age 65, are you disabled? ..... Yes No

B. Eligibility - Please answer all questions

Medicare card number _____

To the best of your knowledge:

1. Did you turn 65 in the last 6 months? ..... Yes No
2. Did you enroll in Medicare Part B in the last 6 months? ..... Yes No
3. Effective date for Part A:_____ Part B: _____
4. Are you applying during a guaranteed issue period? ..... Yes No

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying that 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 entitled to guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with our application.

C. Medicaid Coverage

1. 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, will Medicaid pay your premiums for this Medicare supplement policy? ..... Yes No
2. Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ..... Yes No

D. Medicare Supplement Coverage

1. Do you have another Medicare supplement policy in force? ..... Yes No

   Company name _____ Plan name_____

   If so, do you intend to replace your current Medicare supplement policy with this policy? ..... Yes No

E. Other Health Coverage

1. 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 PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   Start date _____ End date _____

2. 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
3. Was this your first time in this type of Medicare plan? ..... Yes No
4. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ..... 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

   Company name _____ Plan name _____

   Plan type _____ Policy number _____

   Start date _____ End date _____

   (If you are still covered under this plan, leave "End date" blank)

F. Policy Selection

Listed below are the Health First Insurance Medicare supplement plans available in the state of Florida. The policy's effective date will be the latest of: 1) the first day of the calendar month in which you become enrolled in Medicare Part B; or 2) the first day of the calendar month following the date of policy approval.

Select your plan: ___Plan A ___Plan F ___Plan N

Requested effective date _____ *(Requested date is subject to review and approval.)*

G. Health History

Your answers to the following questions will help in determining if you are eligible to apply for the selected plan. **NOTE: If you are applying for coverage during an open enrollment or guaranteed issue period, you are not required to complete this section. Please skip to Section H.**

1. Are you currently hospitalized or confined to a nursing facility; or are you bedridden, or confined to a wheelchair? ..... Yes No
2. Have you been diagnosed with or treated by a physician for **emphysema**, **Chronic Obstructive Pulmonary Disease (COPD)** or **other chronic pulmonary disease**? ..... Yes No
3. Have you been diagnosed with or treated by a physician for **Parkinson's Disease**, **Multiple Sclerosis**, **Muscular Dystrophy**, **Cerebral Palsy**, or **Amyotrophic Lateral Sclerosis** (**Lou Gehrig's Disease** or **ALS**)? ..... Yes No
4. Have you been diagnosed with or treated by a physician for **Alzheimer's**, **senile dementia**, **organic brain disease**, or **any other senility disease**? ..... Yes No
5. Have you been diagnosed with or treated by a physician for **diabetes** in addition to: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? ..... Yes No
6. Do you have diabetes that has ever required **more than 50 units of insulin daily**? ..... Yes No
7. Within the past two (2) years have you been treated by a physician for or been advised by a physician to have treatment for: **liver disease**, **alcoholism** or **drug abuse**, **cirrhosis**, or **mental or nervous disorders**? ..... Yes No
8. Within the past two (2) years have you been treated by a physician for or been advised by a physician to have treatment for a **heart attack**, **congestive heart failure**, **heart valve disorder**, **heart rhythm disorder**, **enlarged heart**, **coronary artery disease** (hardening or narrowing of the artery or

arterial blockage), **carotid artery disease**, **stroke**, **aneurysm**, **peripheral vascular disease**, or **transient ischemic attacks (TIA)**? ..... Yes No

9. Within the past two (2) years have you been treated by a physician for a **degenerative bone disease**, **broken bones due to osteoporosis**, **rheumatoid arthritis**, or have you been **advised to have a joint replacement**? ..... Yes No
10. Have you had, or been advised by a physician to have, any organ transplant, other than a cornea? ..... Yes No
11. Have you been advised by a physician that surgery may be required within the next twelve (12) months for **cataracts**? ..... Yes No
12. Have you ever been diagnosed with **Systemic Lupus**, **Myasthenia Gravis**, **Hemophilia**, **Sickle Cell Anemia**, or **Cystic Fibrosis**? ..... Yes No
13. Have you had or received treatment for cancer (except non-melanoma skin cancer), Hodgkin's Disease, melanoma or leukemia? ..... Yes No
14. Have you had any amputation caused by a disease? ..... Yes No
15. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed yet? ..... Yes No
16. Have you had or received treatment for **End Stage Renal Disease (ESRD)**, **kidney disease**, or have you received **kidney dialysis**? ..... Yes No
17. Have you been confined to a hospital three (3) or more times in the last two (2) years? ..... Yes No
18. Have you tested positive for exposure to the **HIV infection** or been diagnosed as having **Acquired Immune Deficiency Syndrome (AIDS)** or **AIDS Related Complex (ARC)** caused by the HIV infection or other sickness or condition derived from such infection? ..... Yes No
19. Are you taking or have you taken any prescription or over the counter medications within the past twelve (12) months? ..... Yes No

    If yes, please list the name of the drug, original prescribed date, frequency, dosage, and the diagnosis/condition:

    _____

    _____

20. What is your current Height: _____ Weight: _____

H. Payment Information

Your first payment must be included with your application. If you are not approved, your payment will be refunded. If your application is approved, you will receive a bill indicating the amount and your next payment due date. You will also receive an approval letter and a member ID card as proof of coverage.

Please choose how you would like to pay your monthly payment:

1. **Automatic withdrawal:** ___Savings ___Checking

   Primary name on bank account _____

   Name of financial institution _____

   Branch name _____ Branch phone number (_____) _____

   Branch address _____

   Bank account number _____ Bank routing number _____

2. **Credit/Debit card:** ___MasterCard ___Visa ___Discover ___AmEx

   Cardholder name _____

   Credit card number _____ Verification number _____ Exp. date _____/ _____

   Billing address _____

3. **Direct Bill:**

Name _____

Address _____

I. Replacement Form

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE:

Health First Insurance, Inc., 6450 US Highway 1, Rockledge, FL 32955

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

According to your application or information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Health First Insurance, Inc. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep this 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 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 HEALTH FIRST INSURANCE, 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, Medicare cost, Medicare select coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s):

___Additional benefits

___Fewer benefits and lower premiums

___No change in benefits but lower premiums

___Other (please specify): _____

___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:

_____

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 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 prohibits that your replacement policy or certificate may not contain new pre-existing condition waiting periods. The insurer will waive any time periods applicable to pre-existing condition waiting periods in the new policy (or coverage) 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 information has been properly reported. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Replacement Authorization *(I have read and understand the information provided above):*

Signature of Agent, Broker or Other Representative _____

Typed Name and Address of Issuer, Agent or Broker _____

Applicant's Signature _____ Date _____

J. Important Information

(a) You do not need more than one Medicare supplement policy.

(b) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(d) 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.

(e) 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.

(f) 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).

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

I understand the agent or broker may not change or waive any terms or requirements related to this application and its contents, underwriting, premium, or coverage.

___I acknowledge the receipt of "Guide to Health Insurance for People with Medicare" and the Outline of Coverage.

I have read and understand the information provided above:

Signature _____ Date _____

NOTE: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

K. Health First Insurance – Notice of Information Practices

In the course of properly underwriting and administering your insurance coverage, we will rely on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies.

In certain circumstances, and in compliance with applicable law, we or our reinsurers may also release your personal or privileged information in our/their files, to third parties without your authorization. Upon request, you have the right to be told about and to see a copy of items of personal information about you which appear in our files, including information contained in investigative consumer reports. You also have the right to seek correction of personal information you believe to be inaccurate.

In compliance with applicable law, we or our reinsurers may also release information in our/their files, including information in an application, to other insurance companies to which you apply for life or health insurance or to which a claim is submitted.

So that there will be no question that the insurance benefits will be payable at the time a claim is made, we urge you to review your application carefully to be sure the answers are correct and complete.

THE ABOVE IS A GENERAL DESCRIPTION OF OUR INFORMATION PRACTICES. IF YOU WOULD LIKE TO RECEIVE A MORE DETAILED EXPLANATION OF THESE PRACTICES, PLEASE SEND YOUR REQUEST TO: HEALTH FIRST INSURANCE, MEDICARE SUPPLEMENT PRODUCT, 6450 US HIGHWAY 1, ROCKLEDGE, FL 32955.

L. Agent Certification

Agent must complete the following; and if appropriate, the notice of replacement coverage included with this application. All information must be completed or the application will be returned.

1. List any other health insurance policies issued to the applicant:

_____

2. List policies issued which are still in force:

_____

3. List policies issued in the past five (5) years which are no longer in force:

_____

I, the undersigned insurance agent certify:

THAT, I have taken an application for Policy Form No. _____ offered by Health First Insurance, Inc. to

_____ (Applicant).

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of $ _____ which has been paid to me by ( ) Check ( ) Money Order ( ) Credit Card (Check appropriate method of payment).

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Health Care Financing Administration of the Federal Government in connection with this insurance policy being applied for.

Signature of Agent _____ Date _____

Printed Name of Agent _____ FL License # _____

Name of Agency _____ Phone No. _____

Address of Agent or Agency _____

I, the undersigned applicant, have received a copy of this form:

Applicant's Signature _____ Date _____