

MEDICARE SUPPLEMENT PLAN ENROLLMENT FORM



Physicians Plus
INSURANCE CORPORATION
PO Box 2078
Madison, WI 53701-2078

Please type or print firmly and clearly.

1. INFORMATION ABOUT YOU					
First Name	Middle Initial	Last Name		Birthdate	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Street Address	Apt. No.	City	State	Zip Code	County
Telephone ()	Social Security Number		E-mail Address		
Primary Care Physician Name			Location		

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.

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 Physicians Plus to initiate debit entries to my (our) personal account (indicated above) at the named financial institution.

Applicant's Signature: _____ Date: _____

Spouse's Signature (if joint account): _____ Date: _____

3. INFORMATION ABOUT OTHER COVERAGE

A. You must be enrolled in Federal Medicare Parts A, B and D to qualify. Please complete the following:
 Federal Hospital Insurance (Part A) Effective Date (Mo/Day/Yr): _____
 Federal Medical Insurance (Part B) Effective Date (Mo/Day/Yr): _____
 Federal Medical Insurance (Part D) Effective Date (Mo/Day/Yr): _____
 Federal Medicare Identification Number: _____

B. Do you have another Medicare Supplement insurance policy or certificate in force? Yes No
 If yes, with which company? _____
 If yes, do you intend to replace your current Medicare Supplement policy with this policy? Yes No

C. Do you have other health insurance coverage that provides benefits similar to this Medicare Supplement? Yes No
 If yes, with which company? _____
 If yes, what kind of policy? _____

D. Are you covered for medical assistance through the state Medicaid Program? Yes No
 1. Are you covered as a Specified Low-Income Medicare Beneficiary (SLMB)? Yes No
 2. Are you covered as a Qualified Medicare Beneficiary (QMB)? Yes No
 3. Are you covered for other Medicaid medical benefits? Yes No

E. Are you currently covered by another Physicians Plus health insurance policy? Yes No
 If yes, please provide your Member ID Number: _____

4. HEALTH INFORMATION

Please answer the following questions. If you answer “yes” to any, you are not eligible for Physicians Plus Medicare Supplement coverage. Note: If you are applying within six (6) months of enrolling in Medicare Part B or applying under guarantee issue, do not complete this section.

- A. Are you currently:
 - 1. bedridden or confined to a wheelchair? Yes No
 - 2. hospitalized or confined to a skilled nursing facility? Yes No
- B. Within the past year, have you:
 - 1. been hospitalized more than once? Yes No
 - 2. been scheduled to have surgery, but not had such surgery for:
 - a. cataracts? Yes No
 - b. joint replacement? Yes No
 - c. a heart condition? Yes No
 - 3. been diagnosed or treated for internal cancer or 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? Yes No
 - e. 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 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: CONSENT TO RELEASE MEDICAL INFORMATION

Please read carefully the information below and on the reverse side of this form. If you do not understand the provisions of coverage under this Medicare Supplement policy, please ask your Physicians Plus representative for additional explanation.

I’m applying for a Physicians Plus Medicare Supplement Policy. I’ve considered all factors and I believe that the Medicare Supplement policy suits my needs. I authorize Physicians Plus or any other holder of my medical or other information to release to the Center for Medicare and Medicaid Services, their intermediaries or carriers any information needed to administer Title XVIII of the Social Security Act. I authorize any physician, hospital or other provider of health services to disclose to Physicians Plus any information concerning health services provided to me. I understand that under the Select Medicare Supplement Plan, medical care will be covered by Physicians Plus only if it is: 1) Provided by a Physicians Plus network provider; 2) Provided under emergency or urgent circumstances out-of-area, as further detailed in the policy.

Please sign below to acknowledge that you read and understand the information listed above and on the reverse side of this form, including your consent to release medical records.

Signature of Applicant _____ Date _____

AGENT (PLEASE COMPLETE THE FOLLOWING)

Please list below any other health insurance policies that you personally sold to the applicant and which are still in force. (If none, write “None.”) Also, list any policies no longer in force that you sold to the applicant in the past five (5) years.

Policy Description	In Force (indicate Yes or No)	
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Signed at _____ this _____ day of _____, 20 _____

Writing Agent’s Signature Agency No. _____

FOR OFFICE USE ONLY

Group Number	Effective Date	Benefit Plan Level	County	Rate Class	Check Number	Check Amount
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ACCEPTANCE/AGREEMENT

SIGNATURE OF THIS AGREEMENT DOES NOT AUTHORIZE DISCLOSURE OF INFORMATION WHICH IS PROHIBITED UNDER SECTION 631.90, WISCONSIN STATUTES

By signing this application, I understand and agree that:

- A. All statements and answers I've given are complete and accurate to the best of my knowledge and belief;
- B. The Policy I hereby apply for will be effective only when Physicians Plus Insurance Corporation approves this application. Evidence of such approval will be issuance of the Policy; and
- C. I authorize the use of a Social Security Number for identification purposes. Physicians Plus's receipt of your premium check and this application does not mean that Physicians Plus agrees to provide coverage for you. Your coverage, if accepted, begins on the effective date assigned by Physicians Plus. Any illness or change in your condition prior to your assigned effective date must be reported to Physicians Plus immediately. Physicians Plus reserves the right not to provide you with coverage based upon the information contained on this application or provided subsequent to its submittal.

I understand that any insurance agent or broker cannot modify, waive or change in any way this application. I further understand and agree that Physicians Plus, its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorneys' fees) I suffer as a result of any improper advice, action or omission on the part of my health care provider.

Non-Group Application

By signing this application, I understand and agree that A) All statements and answers I provided are complete and true to the best of my knowledge and belief; B) The insurance I hereby apply for will be effective only when Physicians Plus approves this application. Evidence of such approval will be issuance of the Medical Certificate; and C) I authorize the use of a Social Security Number for purpose of identification. I understand that I or my legal representative, not Physicians Plus, represents me for any and all purposes of this policy.

I understand that any insurance agent or broker cannot modify, waive or change in any way this application, any requirement imposed by Physicians Plus, bind coverage or guarantee approval of this application. I further understand and agree that Physicians Plus, its directors, officers, employees and agents shall not be liable for any injury, damage or expense (including attorneys' fees), I suffer as a result of any improper advice, action or omission on the part of any health care provider.

Authorization to Obtain and Release Medical Information

By my signature on this application, I authorize: (1) any physician, medical practitioner, hospital, clinic, medically-related facility or other institution who provided treatment or service to the person listed on the front of this form (to the extent permitted by law) at any time, or their agent(s) (including billing service), having medical information that includes, but is not limited to, identification, medical history, diagnosis, prognosis, consultations, advice, treatments, services, dates of treatments and/or services, test results (excluding any HIV antibody test or genetic test results, but including x-rays) or summary reports, without limitation to period of treatment, diagnostic or therapeutic information, history or type of injury or illness (including pregnancy) and treatment or service, if any, for mental or nervous conditions (excluding psychotherapy notes as defined by law), alcohol or drug abuse, including all programs in which the patient was enrolled as an alcohol or drug abuse patient and (2) any insurance or reinsurance company, service or prepaid benefit plan, plan administrator, consumer reporting agency, employer or personal or business associate having non-medical information about me to disclose to Physicians Plus or their representative(s) (including claims and underwriting departments) all such information (including photographic copies thereof).

I understand that said information will be used by Physicians Plus to determine eligibility for coverage, evaluate and audit claims and determine availability of benefits under the Physicians Plus non-group health insurance policy, benefit plan or other contract, if issued by Physicians Plus. I agree that Physicians Plus may release said information to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claim(s) or as may be otherwise permitted by law or as I may further authorize from time to time. I understand that I will receive a copy of this authorization. I understand that I have the right to inspect or copy the personal health information to be used or disclosed by Physicians Plus.

I understand that this authorization is revocable upon advance written notice given to Physicians Plus at its office in Madison, Wisconsin, except that any information released in reliance thereon and prior to such revocation cannot be retrieved and Physicians Plus and its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand that Physicians Plus may not condition treatment, payment, enrollment or eligibility for benefits on the provision of this authorization. I also understand that I may refuse to sign this authorization; however, in doing so, Physicians Plus may condition payment of claims and services as permitted by law. I understand that this authorization will remain valid for up to 30 months from the date I or my legal representative execute this authorization or, if longer and permitted by law, for so long as the policy is in force under Physicians Plus. I further understand that a photographic copy of this authorization is as valid as the original.

I understand that I may obtain a detailed description of Physicians Plus's Notice of Privacy Practices from www.healthychoicesbigrewards.com or by contacting Physicians Plus directly. Signature of this Agreement does not authorize the use or disclosure of information which is prohibited under Section 631.90 Wisconsin Statutes as it relates to provisions concerning HIV or the use or disclosure of information which is prohibited under Section 631.89 Wisconsin Statutes as it relates to genetic tests.