

Application Booklet for Pennsylvania

This packet contains all required forms for application submission.
Please complete each form according to the instructions on each page.

- **Application**
- **Electronic Funds Transfer Agreement(s)**
- **HIPAA notices**
- **Replacement notice(s)**
- **Notice of Nondiscrimination**
- **Language Assistance Services**

Call our Agent Resource Center (ARC) Hotline at 877.454.0923 Monday - Friday 8:00 a.m. - 5:30 p.m. CST
or email ARCSSL@HealthSpring.com with application submission questions.



APPLICATION for MEDICARE SUPPLEMENT INSURANCE

HealthSpringSM National Health Insurance Company
PO Box 5725, Scranton, PA 18505-5725 • 866-459-4272 • www.HealthSpring.com
Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186



Application is for: New business Reinstatement Phone verification case #(s) _____

- › If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.
- › If only one Applicant, complete Applicant A questions.

A. Personal information

APPLICANT A

Name (First MI Last) _____ Age _____ Date of birth (MM/DD/YYYY) _____ Gender Male Female

Resident address (Street, City, State ZIP) _____ Phone () _____

Mailing address (if different from resident address) _____ Social Security no. (XXX-XX-XXXX) _____

Email address (optional) By providing your email address, you agree to receive marketing content electronically.

APPLICANT B

Name (First MI Last) _____ Age _____ Date of birth (MM/DD/YYYY) _____ Gender Male Female

Resident address (Street, City, State ZIP) – OR check box if same as Applicant A Phone () _____

Mailing address (if different from resident address) _____ Social Security no. (XXX-XX-XXXX) _____

Email address (optional) By providing your email address, you agree to receive marketing content electronically.

Premium discount (see Outline of Coverage for details) APPLICANT A YES NO APPLICANT B YES NO

- 1. a. Do you reside with your spouse, civil union partner or domestic partner (6% "Household Premium" discount)? YES NO YES NO
- b. Do you and another member of your household have a Medicare Supplement policy with HealthSpring National Health Insurance Company or an affiliate of HealthSpring National Health Insurance Company (20% "Multi-Product" premium discount)? YES NO YES NO

2. If you answered YES to 1b, please provide member information if other than Applicant A or Applicant B.
Name (First MI Last) _____ Social Security no. (XXX-XX-XXXX) _____

B. Please provide your Medicare information (as shown on your Medicare card)

APPLICANT A	APPLICANT B
Medicare number _____	Medicare number _____
Hospital (Part A) coverage starts (MM/DD/YYYY) _____	Hospital (Part A) coverage starts (MM/DD/YYYY) _____
Medical (Part B) coverage starts (MM/DD/YYYY) _____	Medical (Part B) coverage starts (MM/DD/YYYY) _____

You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

C. Select a plan and effective date

APPLICANT A Check plan selected: Plan A Plan B Plan F* Plan G Plan N

APPLICANT B Check plan selected: Plan A Plan B Plan F* Plan G Plan N

Requested Medicare Supplement effective date (MM/DD/YYYY) A _____ B _____
 (if no effective date is requested, we will assign the 1st day of the month following the date of this application)

*Plan F is only available if you are first Medicare-eligible before 2020.

D. Are you eligible for Open Enrollment or Guaranteed Issue?

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 (mark YES or NO below with an "X").

To the best of your knowledge:

		APPLICANT A		APPLICANT B	
		YES	NO	YES	NO
1.	a. Did you turn age 65 in the last six (6) months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Did you enroll in Medicare Part B in the last six (6) months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If YES, what is the effective date? (MM/DD/YYYY) A _____ B _____				
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.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If YES,				
	a. Will Medicaid pay your premiums for this Medicare Supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Have 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)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If YES,				
	a. Fill in your START and END dates below (if you are still covered under this plan, leave the END date blank).				
	A START _____ END _____				
	B START _____ END _____				
	b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	c. Was this your first time in this type of Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	a. Do you have another Medicare Supplement policy in force?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	b. If so, with what company and what type plan do you have?				
	A _____				
	B _____				
	c. If so, do you intend to replace your current Medicare Supplement policy with this policy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.				
5.	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	a. If so, with what company and what kind of policy?				
	A _____				
	B _____				
	b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the END date blank.)				
	A START _____ END _____				
	B START _____ END _____				

E. Complete medical questions

IF YOU ARE ELIGIBLE FOR OPEN ENROLLMENT OR GUARANTEED ISSUE (BASED ON YOUR ANSWERS IN SECTION(S) B & D), DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage.

	APPLICANT A		APPLICANT B	
	YES	NO	YES	NO
1. Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Do you have a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Within the past six (6) months, have you been treated for or advised by a medical professional to have treatment for diabetes with hypertension that required three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• heart attack, congestive heart failure, coronary bypass, or stroke? (You should answer NO if your only treatment has been less than three concurrent cardio-vascular medications and your treatment has not altered in the last two (2) years (e.g., change in medications or dosage increases).)				
7. At any time, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)?				
• Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?				
• chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, cirrhosis of the liver or any condition requiring an organ transplant?				
• bipolar disorder, schizophrenia, a paranoid disorder, severe depression, or treatment for depression with medication for two (2) or more years?				
• organic brain disorder?				
• Alzheimer's disease?				
• unrepaired aneurysm, hemophilia, or any other blood disorder?				
• any heart disease requiring a permanent, implantable cardiac defibrillator?				
8. Within the past two (2) years, have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• any cancer, excluding skin cancer (except malignant melanoma)?				
• anemia requiring repeated blood transfusions?				
• alcohol or drug abuse (including counseling)?				
• pancreatitis?				
• seizure?				
9. At any time, have you been treated for or advised by a medical professional to have treatment for an amputation caused by disease or for an organ transplant (other than corneas)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered NO to all questions in this Section, please continue to Part B. >>>

F. Important statements for Applicant to read

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

I hereby apply to HealthSpring National Health Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any false material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

APPLICANT A Telephone number _____ Best time to call _____

APPLICANT B Telephone number _____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

APPLICANT A Signature _____ Date _____

APPLICANT B Signature _____ Date _____

G. Determine your rate class

A B

- Preferred** If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, questions 13a, 14, and 15.
- Standard** If you answered YES to section E, question 13a (tobacco use), and NO to questions 13b, 14, and 15.
- Standard II** If you answered NO to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.
- Standard III** If you answered YES to section E, question 13a (tobacco use), and YES to question 13b, 14, or 15.

Your eligibility for coverage and final rate class is subject to underwriting review. Medications and height and weight impact your rate class. Please refer to the declinable drug list and height and weight chart for guidance.

H. Choose your method of payment

APPLICANT A

Method (select one of the following):

- Bank draft (complete the Electronic Funds Transfer Agreement)
- Direct bill (enclose check payable to **HealthSpring National Health Insurance Company**; do not send cash)
- List bill Group name _____ Group number _____

Mode: Monthly (bank draft or list bill only) Quarterly Semi-annually Annually

Premium (see rate chart in Outline of Coverage) \$ _____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.

If you answered YES to Section A, question 1b, multiply premium by 0.80.

APPLICANT B

Method (select one of the following):

- Bank draft (complete the Electronic Funds Transfer Agreement)
- Direct bill (enclose check payable to **HealthSpring National Health Insurance Company**; do not send cash)
- List bill Group name _____ Group number _____

Mode: Monthly (bank draft or list bill only) Quarterly Semi-annually Annually

Premium (see rate chart in Outline of Coverage) \$ _____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.

If you answered YES to Section A, question 1b, multiply premium by 0.80.

I. Agent use only

Please answer all questions:

1. I certify that I have provided the Applicant(s) with the following documents:
- a. Application packet (phone sales only) b. Guide to Health Insurance for People with Medicare
- c. Outline of Medicare Supplement Coverage d. Other _____

I further certify that I have delivered the documents to the Applicant(s) (check all that apply; must select at least one):

Date _____ In person Mail Email Fax Other (explain) _____

2. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?

APPLICANT A: YES NO APPLICANT B: YES NO

If YES, give name of company, reason, and termination date:

A _____

B _____

NOTES: Please provide additional information that may assist in processing this application (attach a separate sheet if needed).

I certify that I have interviewed the Applicant(s), asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant(s).

Printed name of licensed Agent	Signature of licensed Agent	Writing number	Percentage
Printed name of 2 nd licensed Agent	Signature of 2 nd licensed Agent	Writing number	Percentage

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

HEALTHSPRING NATIONAL HEALTH INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

<input type="checkbox"/> Joint Account – <i>only one form is needed for Joint Account</i> <input type="checkbox"/> APPLICANT A only <input type="checkbox"/> APPLICANT B only		
Proposed Insured Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment:
 Monthly
 Quarterly
 Semi-annually
 Annually

Type of Account:
 Personal Checking Account
 Personal Savings Account
 Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> Change in existing coverage |

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the **⦿** symbols.
⦿ 123456789 ⦿

The Account number is usually to the left of **⦿**. If check number is left of account number, ignore check number.
34567890 ⦿

The Check number should match the upper right corner.
0101

APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to HealthSpring National Health Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize HealthSpring National Health Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event HealthSpring National Health Insurance Company mistakenly deposits funds into my account, I authorize HealthSpring National Health Insurance Company to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR HEALTHSPRING NATIONAL HEALTH INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by HealthSpring National Health Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by HealthSpring National Health Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by HealthSpring National Health Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured)	Payor's Address
Print name of Depositor (as it appears on account)	Signature of Depositor
HNHC-EFT-MULTI	RETURN TO COMPANY
	Date
	09/25

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

HEALTHSPRING NATIONAL HEALTH INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

<input type="checkbox"/> Joint Account – <i>only one form is needed for Joint Account</i> <input type="checkbox"/> APPLICANT A only <input type="checkbox"/> APPLICANT B only		
Proposed Insured Name		Policy Number (if available)
Financial Institution Name and Telephone Number		
9-digit Routing Number	Account Number	Requested Withdrawal Date (1st - 28th)

Withdraw Payment:
 Monthly
 Quarterly
 Semi-annually
 Annually

Type of Account:
 Personal Checking Account
 Personal Savings Account
 Corporate/Business Checking

Name of Employer Group _____

Purpose for submitting this Authorization (check appropriate box(es)):

- | | |
|--|---|
| <input type="checkbox"/> New authorization | <input type="checkbox"/> Change in checking/savings account |
| <input type="checkbox"/> Change in financial institution | <input type="checkbox"/> Change in existing coverage |

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.

0101

PAY TO THE ORDER OF _____ \$ _____

Dollars

The Routing number is 9 digits between the **⦿** symbols.
⦿ 123456789 ⦿

The Account number is usually to the left of **⦿**. If check number is left of account number, ignore check number.
34567890 ⦿

The Check number should match the upper right corner.
0101

APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to HealthSpring National Health Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize HealthSpring National Health Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event HealthSpring National Health Insurance Company mistakenly deposits funds into my account, I authorize HealthSpring National Health Insurance Company to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR HEALTHSPRING NATIONAL HEALTH INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by HealthSpring National Health Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by HealthSpring National Health Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by HealthSpring National Health Insurance Company upon 30 days written notice.

Name of Payor (if other than Insured)	Payor's Address
Print name of Depositor (as it appears on account)	Signature of Depositor
HNHC-EFT-MULTI	RETURN TO COMPANY
	Date
	09/25

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean Health Care Service Corporation, a Mutual Legal Reserve Company, and its subsidiaries.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

Applicant's Name

Name of Applicant's Personal Representative, if applicable

Applicant's Social Security Number

Relationship of Personal Representative to the Applicant

Signature of Applicant

Signature of Personal Representative Date

Date

Signature of Company's Agent

Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean Health Care Service Corporation, a Mutual Legal Reserve Company, and its subsidiaries.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information.
3. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
4. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
6. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
7. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
8. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
9. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

Applicant's Name

Name of Applicant's Personal Representative, if applicable

Applicant's Social Security Number

Relationship of Personal Representative to the Applicant

Signature of Applicant

Signature of Personal Representative Date

Date

Signature of Company's Agent

Date

A signed copy of this form will be provided with the policy if issued and any other time upon request.

**AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S
PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES
("Authorization")**

1. I hereby authorize the use and disclosure of all my health information to Health Care Service Corporation, a Mutual Legal Reserve Company, and its subsidiaries ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from the Company.

APPLICANT A Name	Name of APPLICANT A Personal Representative, if applicable
APPLICANT A Social Security Number	Relationship of Personal Representative to APPLICANT A
APPLICANT A Signature	Signature of Personal Representative Date
Date	
APPLICANT B Name	Name of APPLICANT B Personal Representative, if applicable
APPLICANT B Social Security Number	Relationship of Personal Representative to APPLICANT B
APPLICANT B Signature	Signature of Personal Representative Date
Date	
Signature of Company's Agent	Date

A signed copy of this form will be provided to you.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the HealthSpring National Health Insurance Company (HNHIC) with the application.

A copy of this form must also be left with the Applicant.

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

HEALTHSPRINGSM NATIONAL HEALTH INSURANCE COMPANY

PO Box 5725, Scranton, PA 18505 • 866-459-4272

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

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by HealthSpring National Health Insurance Company. 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 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 ISSUER, AGENT, OR BROKER

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 coverage is being purchased for the following reason (check one):

- | | |
|---|---|
| <p>Applicant A</p> <p><input type="checkbox"/> additional benefits</p> <p><input type="checkbox"/> no change in benefits, but lower premiums</p> <p><input type="checkbox"/> fewer benefits and lower premiums</p> <p><input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> disenrollment from a Medicare Advantage plan; please explain reason for disenrollment _____</p> <p><input type="checkbox"/> other (please specify) _____</p> <p>_____</p> | <p>Applicant B</p> <p><input type="checkbox"/> additional benefits</p> <p><input type="checkbox"/> no change in benefits, but lower premiums</p> <p><input type="checkbox"/> fewer benefits and lower premiums</p> <p><input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> disenrollment from a Medicare Advantage plan; please explain reason for disenrollment _____</p> <p><input type="checkbox"/> other (please specify) _____</p> <p>_____</p> |
|---|---|

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 premiums 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.

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE
RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.**

Agent/Broker printed name and signature

Date

Applicant A signature

Date

Applicant B signature

Date

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the HealthSpring National Health Insurance Company (HNHIC) with the application.

A copy of this form must also be left with the Applicant.

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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.

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- | | |
|--|--|
| <p>Applicant A</p> <p><input type="checkbox"/> additional benefits</p> <p><input type="checkbox"/> no change in benefits, but lower premiums</p> <p><input type="checkbox"/> fewer benefits and lower premiums</p> <p><input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> disenrollment from a Medicare Advantage plan; please explain reason for disenrollment _____</p> <p><input type="checkbox"/> other (please specify) _____</p> | <p>Applicant B</p> <p><input type="checkbox"/> additional benefits</p> <p><input type="checkbox"/> no change in benefits, but lower premiums</p> <p><input type="checkbox"/> fewer benefits and lower premiums</p> <p><input type="checkbox"/> my plan has outpatient prescription drug coverage and I am enrolling in Part D</p> <p><input type="checkbox"/> disenrollment from a Medicare Advantage plan; please explain reason for disenrollment _____</p> <p><input type="checkbox"/> other (please specify) _____</p> |
|--|--|

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 premiums 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.

**DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE
RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.**

Agent/Broker printed name and signature

Date

Applicant A signature

Date

Applicant B signature

Date

Notice of Nondiscrimination

Discrimination is against the law.

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation).

We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

To receive reasonable modifications, communication aids, or language assistance services free of charge, please call the customer service toll-free number listed on the back of your Member ID card.

If you believe that we have failed to provide any of these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Health Care Service Corporation (HCSC)

Attn: Office of Civil Rights Coordinator
300 E. Randolph St., 35th Floor
Chicago, IL 60601

Phone: **1-855-664-7270 (voicemail)**

TTY/TDD: **1-855-661-6965**

Fax: **1-855-661-6960**

You can file a grievance by phone, mail or fax. If you need help filing a grievance, please call the customer service toll-free number listed on the back of your Member ID card.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW,
Room 509F,
HHH Building
Washington, DC 20201

1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at: **<http://www.hhs.gov/ocr/office/file/index.html>**

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

English:	<p>ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call the plan for more information or speak to your provider.</p>
Español (Spanish):	<p>ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También puede solicitar, sin costo alguno, servicios o herramientas especiales para acceder a la información en formatos accesibles. Llame al plan para obtener más información o hable con su proveedor.</p>
中文 (Chinese Mandarin):	<p>注意：如果您说中文，我们可以为您提供免费的语言协助服务。我们还免费提供适当的辅助设备和服务，以无障碍格式提供信息。请致电计划以获取更多信息或与您的服务提供者联系。</p>
中文 (Chinese Cantonese):	<p>注意：如果您說中文，我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務，以無障礙格式提供資訊。請致電本計劃查詢更多資訊或諮詢您的醫療服務提供者。</p>
Tagalog (Tagalog):	<p>PAGBIGAY-PANSIN: Kung nagsasalita ka ng wikang tagalog, available para sa iyo ang mga serbisyo ng libheng tulong sa wika. Available din nang walang bayad ang mga wastong dagdag na tulong at serbisyo na makapagbibigay-impormasyon sa mga naa-access na format. Balikan ang plano para sa higit pang impormasyon o makipag-usap sa iyong provider.</p>
Français (French):	<p>ATTENTION : Si vous parlez français, des services d'assistance linguistique gratuits peuvent être mis à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez votre régime d'assurance maladie pour obtenir des informations supplémentaires, ou adressez-vous à votre prestataire.</p>
Việt (Vietnamese):	<p>CHÚ Ý: Nếu quý vị nói tiếng việt, các dịch vụ hỗ trợ ngôn ngữ miễn phí sẽ có sẵn cho quý vị. Các dịch vụ và trợ giúp bổ sung phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng có sẵn miễn phí. Hãy gọi cho chương trình để biết thêm thông tin hoặc trao đổi với nhà cung cấp dịch vụ của quý vị.</p>
Deutsch (German):	<p>BITTE BEACHTEN: Wenn Sie deutsch sprechen, stehen Ihnen kostenlose sprachliche Hilfsdienstleistungen zur Verfügung. Geeignete Hilfsmittel und Dienstleistungen zur Bereitstellung von Informationen in barrierefreien Formaten sind ebenfalls kostenlos verfügbar. Für weitere Informationen wenden Sie sich bitte an den Kundendienst Ihrer Versicherung bzw. an Ihren Versicherungsberater.</p>

한국어
(Korean):

참조: 한국어를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 도구 및 서비스도 무료로 제공해 드립니다. 자세한 정보는 플랜에 전화하거나 서비스 제공업체에 문의하십시오.

Русский
(Russian):

ВНИМАНИЕ: Если вам удобнее для общения русский язык, вы можете воспользоваться бесплатными услугами языковой поддержки. Также доступны необходимые вспомогательные средства и услуги предоставления информации в доступном формате для людей с ограниченными возможностями. Для получения дополнительной информации позвоните или обратитесь к своему поставщику.

اللغة العربية
(Arabic):

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل بالخطة للحصول على مزيد من المعلومات أو للتحدث مع مقدم الخدمة الذي تتعامل معه.

हिंदी
(Hindi):

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उचित सहायक साधन और सेवाएं भी निःशुल्क उपलब्ध हैं। प्लान के बारे में अधिक जानकारी के लिए कॉल करें या अपने प्रदाता से बात करें।

Italiano
(Italian):

ATTENZIONE: Se parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi adeguati per fornire informazioni in formati accessibili. Chiami il numero corrispondente al Suo piano per ulteriori informazioni o si rivolga al Suo fornitore.

Português
(Portuguese):

ATENÇÃO: Se fala português, tem à sua disposição serviços gratuitos de assistência linguística. Também estão disponíveis equipamentos e serviços de assistência adequados que lhe permitem ter acesso às informações em formatos acessíveis, de forma gratuita. Contacte o plano para obter mais informações ou fale com o seu prestador.

Kreyòl Ayisyen
(Haitian Creole):

ATANSYON: Si ou pale kreyòl ayisyen, w ap jwenn sèvis asistans lengwistik gratis. Gen èd ak sèvis oksilyè ki apwopriye pou bay enfòmasyon nan fòm ki aksesib, ki disponib gratis tou. Rele plan an pou jwenn plis enfòmasyon oswa pou w pale ak pwofesyonèl swen sante w la.

Polski
(Polish):

UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Odpowiednie wsparcie i usługi pomocnicze w celu zapewnienia informacji w przystępnych formatach są również dostępne bezpłatnie. Dodatkowe informacje można uzyskać dzwoniąc do planu lub rozmawiając ze świadczycielką.

日本語
(Japanese):

注：お客様が[日本語]を話す場合は、無料の言語アシスタンス・サービスを利用できます。アクセスしやすい形式で情報提供を行うための、適切な補助器具やサービスも無料でご利用いただけます。詳細はプランにお電話いただくか、プロバイダーにご相談ください。