



INSURING LIVES • SUPPORTING WOMEN • SERVING COMMUNITIES™

230 Sixteenth Street • Rock Island, IL 61201

Medicare Supplement Administration

P.O. Box 10851 • Clearwater, FL 33757-8851

(877) 815-8877

*Royal Neighbors of America
is dedicated to enriching the lives
of women and those they care about.*

**APPLICATION FOR
Medicare Supplement Insurance
and Membership**

ROYAL NEIGHBORS OF AMERICA

Home Office: Rock Island, Illinois

Mail Application To: Administrative Office: Medicare Supplement Administration, P.O. Box 10851, Clearwater, FL 33757-8851

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICATION #:

(Exactly as shown on your Medicare ID Card)

Last Name First Name MI

RESIDENCE ADDRESS

Street:

City:

State:

Zip Code:

EMAIL Address:

Check the Plan You Prefer:

- | | |
|--|--|
| <input type="checkbox"/> Standardized Plan A | <input type="checkbox"/> Standardized Plan E |
| <input type="checkbox"/> Standardized Plan B | <input type="checkbox"/> Standardized Plan F |
| <input type="checkbox"/> Standardized Plan C | <input type="checkbox"/> Standardized Plan G |
| <input type="checkbox"/> Standardized Plan D | |

AGE	DATE OF BIRTH			SEX
	Month	Day	Year	<input type="checkbox"/> Male <input type="checkbox"/> Female

AREA CODE	TELEPHONE NUMBER

SOCIAL SECURITY NUMBER

MEDICARE INFORMATION

Date first enrolled in Medicare Part B: _____

Medicare Claim Number: _____

Are you a member of Royal Neighbors of America? Yes No

Camp/Chapter Number: _____ Camp/Chapter Location (City & State) _____

UNDERWRITING RISK CLASSIFICATION QUESTION

Have you used any form of tobacco in the past five years? Yes No
(If answer is "No", you are eligible for preferred rates, if "Yes", standard rates apply.)
(You do not have to answer this question if you are applying during open enrollment or a guaranteed issue period.)

Do you take prescription drugs? Yes No

PREMIUM CALCULATION:

PREMIUM: \$ _____

CERTIFICATE FEE: 20.00

INITIAL PAYMENT: \$ _____

PLEASE SELECT THE METHOD OF PAYMENT YOU WANT

Bank Draft Annual Semiannual Quarterly Monthly Bank Draft

PART I – HEALTH QUESTIONS

YOU ARE NOT REQUIRED TO ANSWER HEALTH QUESTIONS 1-10 IF YOU ARE IN AN OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. PLEASE SEE PAGE 5 FOR AN EXPLANATION OF OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION.

IF YOU ANSWER "YES" TO ANY OF THE HEALTH QUESTIONS 1-10, YOU ARE NOT ELIGIBLE FOR COVERAGE.

- | | | |
|--|------------------------------|-----------------------------|
| 1. Are you bedridden or confined to a wheelchair? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Are you currently hospitalized or confined to a nursing facility; or have you been hospitalized two or more times within the past year? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Within the past two years, have you been advised to have kidney dialysis? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Within the past two years have you had coronary or carotid artery disease (not including high blood pressure), a heart attack, atrial fibrillation, congestive heart failure, stroke, Transient Ischemic Attack (TIA), heart valve surgery or peripheral vascular disease or been treated with a heart defibrillating device or pacemaker? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Within the past two years, have you had or been treated for internal cancer, leukemia or malignant melanoma, Hodgkin's Disease, disabling arthritis, degenerative disc disease, cirrhosis of the liver, or alcohol or drug abuse? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Within the past two years, have you been advised to have surgery for cataracts, joint replacement, a heart condition or other surgery but not had such surgery? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Have you had or been told by your physician you have Parkinson's disease, osteoporosis with fractures, Paget's disease of the bone, spinal stenosis, Alzheimer's disease, Organic Brain Syndrome, senile dementia or other senility disorders, emphysema, chronic bronchitis, Chronic Obstructive Pulmonary Disease (COPD), other chronic lung disease, Myasthenia Gravis, Lupus, Multiple or Amyotrophic Lateral Sclerosis, paralysis; Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Have you had or been told by your physician you needed an organ transplant or amputation due to disease? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Have you been advised by a physician to have medical tests, treatment or therapy that has not been performed? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Are you an insulin dependent diabetic? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Requested Effective Date: _____

Special Requests: _____

PART II – MEDICAL COVERAGE REPLACEMENT (MUST BE COMPLETED)

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 certificate/policy, or that you had certain rights to buy such a certificate/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.”

To the best of your knowledge:

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? _____
- (d) Did you enroll in Medicare Part C in the last 6 months? Yes No
- (e) If yes, what is the effective date? _____
- (f) Did you enroll in Medicare Part D in the last 6 months? Yes No

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

- If yes,
- (a) Will Medicaid pay your premiums for this Medicare supplement certificate? 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 (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates. If you are still covered under this plan, leave “END” blank. 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 certificate? Yes No
- (c) Was this your first time in this type of Medicare plan? Yes No
- (d) Did you drop a Medicare supplement certificate/policy to enroll in this plan? Yes No

4. (a) Do you have another Medicare supplement policy/certificate 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/certificate with this certificate? 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 yes, with what company and what kind of certificate/policy? _____

- (b) What are your dates of coverage under the other certificate/policy? (If you are still covered under the policy/certificate, leave “END” blank.) START END
____/____/____ ____/____/____

IMPORTANT STATEMENTS TO BE READ AND SIGNED BY THE APPLICANT

- (1) You do not need more than one Medicare Supplement Insurance Certificate/Policy.
- (2) If you purchase this certificate, 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 Insurance Certificate/Policy.
- (4) If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance Certificate must 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. Upon receipt of timely notice, the issuer must either return to the certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. If you are no longer entitled to Medicaid, your suspended Medicare supplement certificate/policy (or, if that is no longer available, a substantially equivalent certificate) will be reinstated, if requested, within 90 days of losing Medicaid eligibility. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (5) If you are eligible for, and have enrolled in a Medicare supplement certificate 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 certificate can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement certificate/policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement certificate/policy (or, if that is no longer available a substantially equivalent certificate) will be reinstated if requested within 90 days of losing your employer or union based group health plan. If the Medicare supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Certificate 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).

To the best of my knowledge and belief, all answers to the questions contained in this application are true and complete. I understand that any change in my health prior to delivery of this certificate may be used in the underwriting evaluation. I have received an outline of coverage for the certificate applied for and a *Guide To Health Insurance for People With Medicare*.

Pre-existing conditions are covered immediately upon effective date under a Royal Neighbors of America Medicare Supplement Certificate. You are not required to satisfy any waiting period.

If not a current member of Royal Neighbors of America, I apply to become a member as indicated by my signature below. As a member of RNA I will uphold the principles of Faith, Courage, Modesty, Unselfishness, and Endurance on which RNA was founded more than 100 years ago.

Signed At: _____
(City /State)

Applicant's Signature _____

Dated: _____
(Month/Day/Year)

OPEN ENROLLMENT/GUARANTEED ISSUE PERIOD INFORMATION

Open Enrollment: You are eligible for Open Enrollment and will not need to answer Health Questions 1-10 on Page 2 of this application if (a) you are within six months of purchasing Medicare Part B coverage for the first time; or (b) you were eligible for early Medicare and you are within six months of turning age 65.

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997:

The following are definitions of the categories of individuals who are eligible for Guaranteed Issue under the Balanced Budget Act of 1997:

- (a) Enrolled under an employee welfare benefit plan that: (1) provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide some or all such supplemental health benefits to the individual; or (2) is primary to Medicare and the plan terminates or the plan ceases to provide some or all health benefits to the individual because the individual leaves the plan; or
- (b) Enrolled in a Medicare Advantage plan or Program of All-Inclusive Care for the Elderly (PACE) and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material policy provision, or a material misrepresentation was made to the individual; or
- (c) Enrolled in a Medicare risk contract, health care prepayment plan, cost contract or Medicare Select plan, or similar organization, and the organization's certification or plan is terminated or specific circumstances permit discontinuance including, but not limited to, a change in residence of the individual, the plan is terminated within a residence area, the organization substantially violated a material certificate/policy provision, or a material misrepresentation was made to the individual; or
- (d) Enrolled in a Medicare Supplement certificate/policy and coverage discontinues due to insolvency, substantial violation of a material certificate/policy provision, or material misrepresentation; or
- (e) Enrolled under a Medicare Supplement certificate/policy, terminates and enrolls for the first time in a Medicare Advantage, a risk or cost contract, or a Medicare Select plan, a PACE provider, and then the insured person terminates coverage within 12 months of enrollment; or
- (f) Upon *first* becoming eligible for benefits under Part A and enrolled in Part B, if eligible, you enrolled in a Medicare Advantage or PACE provider and then disenrolled within 12 months.

Documentation of these events must be submitted with the application. You must apply within 63 days of the date of termination of previous coverage in order to qualify as an eligible person.

AUTHORIZATION MUST BE COMPLETED AND SIGNED

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, Medicare, Medical Information Bureau (MIB), consumer reporting agency, Division of Motor Vehicles, or the Veterans Administration having information as to diagnosis, treatment or prognosis with respect to the physical or mental condition or having non-medical information, concerning me to release and disclose the entire medical record and any other protected health or other information concerning me within the past ten (10) years, without restrictions, to **Royal Neighbors of America (RNA)**, its agents, employees, representatives or its reinsurers. This includes information on the treatment of alcohol, drug and tobacco abuse, and psychiatric diagnosis and treatment. In order to facilitate the rapid transmission of such information, I authorize all the sources named above, except MIB, Inc., to give such information to any legal representative or agent employed by **RNA**. Medical information will not be used to decline coverage if you are in Open Enrollment or Guaranteed Issue Period.

I understand that the protected information is to be disclosed under this authorization so that **RNA** may underwrite my application for Medicare Supplement insurance, determine eligibility for insurance, risk rating or certificate (policy) issuance determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and conduct other legally permissible activities that relate to any coverage I have, or have applied for, with **RNA**. Any protected information obtained will not be released by **RNA**, or its reinsurers, to any person or organization **EXCEPT** to reinsuring companies, MIB, Inc., other life/health insurance organizations or fraternal benefit societies with which I have insurance contracts or to whom I may apply for insurance or to whom a claim for benefits may be submitted; or other persons or organizations performing business or legal services in connection with my application, insurance certificate or claim for benefit, or as may be otherwise lawfully required or as I may further authorize.

I understand that this authorization shall remain in force for **thirty (30) months** from the date shown below if used in connection with an application for an insurance certificate, an application for reinstatement of an insurance certificate, or a request for change in certificate benefits; or for the duration of a claim if used for the purpose of collecting information in connection with a claim for benefits under a certificate.

I understand and agree that a copy of this authorization is as valid as the original and that I or my authorized representative will receive a copy of this authorization with my certificate. I understand and agree that this authorization may be revoked by me at anytime in writing, by sending a written notice of revocation to **RNA**, Medicare Supplement Administration, P. O. Box 10851, Clearwater, Florida 33757-8851. I agree that **RNA** shall be fully protected if it acts in reliance on this authorization prior to receiving notice of revocation or to the extent that **RNA** has a legal right to contest a claim under an insurance contract. Any information that is disclosed pursuant to this authorization may be redisclosed as provided herein or as required or authorized by law and may then no longer be covered by federal rules governing privacy and confidentiality of health information.

I understand that if I refuse to sign this authorization to release the complete medical records and protected health or other information or have any restriction on the release of the protected health information of me, **RNA** will not be able to process the application, or if coverage has been issued, may not be able to make any benefit payments.

Printed Name of Applicant _____

Signature of Applicant _____

Signed this _____ day of _____, 20_____.

AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the certificate.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

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

2. List any other health insurance certificate/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 accurately recorded the information supplied by the Applicant; and
2. I have given an outline of coverage for the certificate applied for and a *Guide To Health Insurance for People With Medicare* to the Applicant.

Agent's Signature: _____

Date: _____

Agent's Printed Name: _____

Agent No.: _____

(Attach Voided Check)

AUTHORITY TO HONOR PREMIUM CHECKS

AUTHORIZATION	IN FAVOR OF: <u>Royal Neighbors of America</u>		AUTHORIZATION	
	Administrative office <u>P.O. Box 10851, Clearwater, FL 33757-8851</u>			
	Name of Bank Customer: _____			Certificate Numbers
	Insured's Name: _____			
	Account Number : _____			Routing Number: _____
	To (Name of Bank): _____			
	Address of Bank: _____			
You are hereby authorized, as a convenience to me, to honor and charge my account for checks, drafts and other orders, including without limitation any order initiated by electronic means, drawn by The Society indicated above, (hereinafter referred to as THE SOCIETY), on my account by and payable to the order of The Society for the payment of premiums provided there are sufficient collected funds in such account to pay the same upon presentation. I agree that your rights in respect to each such check or other order drawn by The Society shall be the same as if it were a check drawn on you and signed personally by me. This authority is to 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 check or other orders drawn by The Society. I further agree that if any such checks or other orders drawn by The Society be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.				
Date _____		Signature of Depositor _____		
Signature must be the same as on the signature card at bank, and if a company account the name of the account must be shown.				
To: The Bank above				
In consideration of your compliance with the individual authorization of your depositors to pay checks, drafts or orders, drawn and signed by us to our order, we agree: <ul style="list-style-type: none"> ➤ To indemnify you and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment of such insurance premiums including any costs or expenses reasonably incurred in connection therewith. ➤ In the event that any such check, draft or order shall be dishonored, whether with or without cause, and whether intentionally or inadvertently, to indemnify you for such loss even though dishonor results in forfeiture of the insurance. ➤ To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to said authorization and direction or in any manner arising by reason of your participation in this plan of premium collection. 				