



1717 W. Broadway-P.O. Box 8190
Madison, WI 53708-8190
www.wpsic.com



MEDICARE SUPPLEMENT ENROLLMENT APPLICATION

INSTRUCTIONS: YOU MAY NOT APPLY MORE THAN THREE (3) MONTHS PRIOR TO BECOMING ELIGIBLE FOR COVERAGE. PLEASE COMPLETE ALL INFORMATION REQUESTED ON APPLICATION, AND MAIL THIS ENTIRE FORM IN THE POSTAGE-PAID ENVELOPE ENCLOSED. IF APPLICATION IS BEING COMPLETED THROUGH AN AGENCY, THE AGENT MUST COMPLETE AND SUBMIT THE AGENCY FORM FOR MEDICARE SUPPLEMENT ENROLLMENT.

Reason for Application: Initial Application Adding Benefit Riders Removing Benefit Riders Adding Dental

How did you learn about this WPS plan? _____

1. APPLICANT INFORMATION (YOU MUST HAVE MEDICARE PARTS A AND B TO ENROLL.)

Last Name _____ First _____ Middle _____

Date of Birth _____ Sex _____

Street Address _____ City _____

County _____ State _____ Zip Code _____

Telephone No. (Home) (_____) _____

E-Mail Address _____

Social Security No. _____ Medicare No. _____

Medicare **Part A** Effective Date: _____ Medicare **Part B** Effective Date: _____

Is anyone who resides in your household* already enrolled or currently applying for a WPS Medicare Supplement?

- Yes No

If yes, that person's full name _____

Social Security No. _____ Effective date of policy _____

Where would you like your policy delivered? Applicant Agent

2. EFFECTIVE DATE

If WPS approves you for coverage under this Medicare Supplement policy, the policy's effective date will be the latest of:

- A. The first day of the calendar month in which you become enrolled in Medicare Part B, or
- B. The first day of the calendar month following the date of WPS approval; or
- C. Requested effective date ____/01/____ (must be the first of the month)

Please see below if adding Foreign Travel after the initial effective date.

3. SELECT YOUR PLAN (When adding or removing optional riders, choose all of the benefits you are electing to keep.)

BASIC PLAN ONLY

BASIC PLAN PLUS RIDERS YOU'RE REQUESTING

- Medicare 100% Part A Deductible **OR** Medicare 50% Part A Deductible
- Medicare Part B Deductible **OR** Medicare Part B Copayment or Coinsurance
- Medicare Part B Excess Charges
- Additional Home Health Care
- Foreign Travel: Effective Date _____ (if adding after initial effective date)

DENTAL underwritten by Delta Dental of Wisconsin. The dental plan is only available if you select a BASIC PLAN.

Do you have other dental coverage that is not canceling and will not be replaced by the requested dental coverage?

- Yes No (If you answered "Yes" to this question, you are not eligible for the dental plan coverage.)

*Household: Two or more individuals who reside together in the same dwelling. For purposes of this definition, "dwelling" means a single home, condominium unit, or apartment unit within an apartment.

4. ELIGIBILITY/IMPORTANT INFORMATION/HEALTH QUESTIONS

A. You are automatically accepted for coverage, and no health questions are required to be answered if:

- You are applying three calendar months before you enroll in Medicare Part B.
- You are applying in the calendar month in which you enroll in Medicare Part B.
- You are applying within six calendar months immediately following the month you enroll in Medicare Part B.
- You are applying within six calendar months beginning with the month of your 65th birthday if you're currently enrolled in Medicare Part B.
- You are currently insured by WPS, are losing eligibility and applying for this coverage at least 30 days prior to your coverage termination.
- You are eligible for guaranteed issue. Guaranteed issue applies when you lose or terminate health coverage under certain circumstances, providing you apply within 63 days of the termination date of your prior health plan. You must provide a copy of the termination notice you received from your prior plan along with your application. This notice must verify the circumstances of your prior plan's termination and also describe your right to guaranteed issue of Medicare supplement insurance.

B. IMPORTANT INFORMATION

NOTE: *If you have other Medicare supplement insurance that you don't intend to cancel, you aren't eligible for this WPS Medicare Supplement Policy.*

1. You do not need more than one Medicare supplement, Medicare cost or Medicare select policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. If you are eligible for benefits under Medicaid, you may not need a Medicare supplement, Medicare cost or Medicare select policy.
4. If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement, Medicare cost or Medicare select 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, Medicare cost or Medicare select 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, Medicare cost or Medicare select 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 suspension.
5. If you are eligible for and have enrolled in a Medicare supplement or Medicare cost 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 or Medicare cost 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 or Medicare cost policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement or Medicare cost 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 or Medicare cost 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 suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement or Medicare cost 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). Please see the booklet entitled "Wisconsin Guide to Health Insurance for People with Medicare" which you received at the time you were solicited to purchase this policy.

- C. Health questions are required to be answered if you are applying at any other time other than stated in A. above.
- (1) In the past **two years**
- (a) Have you been hospitalized (more than 24 hours) three times or more, or been recommended to have inpatient surgery that hasn't yet been performed? Yes No
- (b) Have you been hospitalized for the treatment of mental or nervous disorders including alcohol or drug abuse? Yes No
- (c) Have you had or been told by your physician you had 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, or peripheral vascular disease? Yes No
- (d) Have you had or been told by your physician you had diabetes that requires insulin; liver disease; or broken bones due to osteoporosis? Yes No
- (e) Have you had or received treatment for End Stage Renal Disease (ESRD) kidney disease, or have you received kidney dialysis? Yes No
- (2) In the past **five years**
- (a) Have you had or received treatment or surgery for cancer (except for non-melanoma skin cancer), Hodgkin's Disease, melanoma or leukemia? Yes No
- (b) Have you had, or been recommended to have any organ transplant other than of the cornea? Yes No
- (3) Have you ever been diagnosed with Multiple Sclerosis, Muscular Dystrophy, Cerebral Palsy, Amyotrophic Lateral Sclerosis (Lou Gehrig's Disease or ALS), Parkinson's Disease, Alzheimer's Disease, Systemic Lupus, Myasthenia Gravis, Hemophilia, Sickle Cell Anemia, Emphysema, or Cystic Fibrosis? Yes No
- (4) Are you currently confined to a nursing facility? Yes No

5. PREMIUM/PAYMENT OPTIONS

Please check the mode of payment you're requesting in either A., B., or C. below).

A. AUTOMATIC WITHDRAWAL. We electronically transfer your premium directly from your bank account at the frequency you request. **(If you select this option, please complete Automatic Withdrawal Payment Authorization Form.)**

- Monthly Quarterly Semiannually Annually

With this option your first premium payment can be drafted from your bank account.

B. DIRECT BILL. We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.

- Monthly Quarterly Semiannually Annually

C. CREDIT/DEBIT CARD. **(If you select this option, please complete Credit/Debit Card Authorization Form.)**

- Initial Premium Deposit Monthly Quarterly Semiannually Annually

With this option your first premium payment can be charged to your credit card.

Premium Paid \$ _____ (If application is submitted through an agency, please complete Section 9.)

**Please submit your initial premium payment with your application. Mail your payment and application to:
WPS • P.O. Box 9 • Madison, Wisconsin 53701-0009, or use the postage-paid envelope provided.**

6. QUESTIONS

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 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 your application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No below with an "X"

Questions about you

- A. (1) Did you turn age 65 in the last 6 months? Yes No
- (2) Did you enroll in Medicare Part B in the last 6 months? Yes No
- (3) If yes, what is the Medicare Part B effective date? _____

Questions about Medicaid

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

Questions about Medicare replacement coverage

- C. (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 health maintenance organization or preferred provider organization), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START ____ / ____ / ____ END ____ / ____ / ____
- (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

Questions about Medicare Supplement, Medicare Select

- D. (1) Do you have another Medicare supplement policy in force? Yes No
- (2) If so, with what company, and what plan do you have?

- (3) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

Questions about any other health insurance

- E. Have you had coverage under any other health insurance within the past 63 days? Yes No
(For example an employer, union, or individual plan)
- (1) If so, with what company and what kind of policy?

- (2) What are your dates of coverage under the other policy?

START ____ / ____ / ____ END ____ / ____ / ____
(If you are still covered under the other policy, leave "END" blank.)

7. ACCEPTANCE/AGREEMENT

NOTE: Signature on this agreement does not authorize disclosure of information prohibited under Section 631.90, Wisconsin Statutes.

By my signature below, I understand and agree that all statements and answers I've given are complete and true to the best of my knowledge and that the policy for which I'm applying will be effective only after WPS approves this application. Evidence of such approval will be issuance of the policy.

I hereby authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, Medical Information Bureau, Inc. ("MIB"), consumer reporting agency, or other organization, institution, or person that has any record or knowledge of me to give to Wisconsin Physicians Service Insurance Corporation ("WPS") or its legal representative, reinsurers, authorized agents or designees, any and all information in any form (excluding psychotherapy notes) about me concerning diagnosis, treatment and prognosis for any physical or mental condition, history or character, general reputation, personal traits, and mode of living, including, but not limited to, all medical and health care records. The information authorized for release shall not include whether the individual has obtained a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV or the results of such a test, if obtained by the individual.

I understand the information obtained by this authorization will be used by WPS to determine eligibility for coverage under this Medicare supplement policy and that my failure to authorize the release of said information might result in a refusal to issue or provide coverage. I agree that WPS may release said information to MIB or to WPS' reinsuring companies, representative(s) or other person(s) performing business or legal services in connection with this application or as may be permitted or required by law, or as I may further authorize from time to time.

I understand that I may revoke this authorization by providing advance written notice of termination to WPS at its office in Madison, Wisconsin, and that any information released in reliance upon this authorization and prior to such revocation cannot be retrieved. In such case, WPS, its directors, officers, employees and agents shall not be held responsible or liable for such release. I understand this authorization will remain valid for 30 months from the date I execute this authorization unless revoked by me in writing prior to the end of that 30-month period.

I understand that I should retain a copy of this completed authorization for my own records, and that a photographic copy shall be as valid as the original. I understand that once information is disclosed pursuant to this authorization, federal privacy laws may no longer protect it and the person or entity that receives the information may re-disclose it.

I understand that an insurance agent or broker cannot modify or waive the terms, conditions, or provisions of the insurance policy, application or requirement imposed by WPS, nor bind coverage or guarantee approval of coverage. I further understand that WPS, 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.

I understand and acknowledge that any person who, with intent to defraud or knowledge that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false and deceptive statement is committing a fraudulent act, which is a crime. I further understand and acknowledge that in some states, any person who, for the purpose of misleading an insurer or other person, conceals significant information from an application or claim is committing a fraudulent act.

I'm applying for a Medicare supplement policy. I've considered all factors and believe this Medicare supplement policy suits my needs. I received the Medicare supplement outline of coverage and the booklet entitled "Wisconsin Guide to Health Insurance for People with Medicare" before applying for this policy.

This application is not complete unless signed and dated. IMPORTANT: Please read and sign page 6 if you are replacing a current Medicare Supplement, Medicare Cost, Medicare Select or Medicare Advantage or health insurance policy/certificate with this policy.

Sign Here   _____
Applicant's Signature

Date

8. IF YOU ARE REPLACING COVERAGE, READ & SIGN THIS SECTION

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE OR EXISTING ACCIDENT AND SICKNESS INSURANCE

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway, P.O. Box 8190, Madison, Wisconsin 53708-8190

According to your application or information you have furnished, you intend to terminate existing Medicare Supplement, Medicare Cost, Medicare Select or Medicare Advantage insurance and replace it with a policy to be issued by Wisconsin Physicians Service Insurance Corporation. 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, Medicare Cost, Medicare Select or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare Supplement, Medicare Select 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 WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement, Medicare Cost, Medicare Select or Medicare Advantage policy will not duplicate your existing Medicare Supplement, Medicare Cost, Medicare Select or 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 provides 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.

(Signature of Agent, Broker or Other Representative) *Signature not required for direct response sales*

(Typed Name and Address of Issuer, Agent or Broker)

Agency No.

Sign Here	<div style="font-size: 2em; font-weight: bold; text-align: center; margin-bottom: 5px;">X</div> <hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p style="text-align: center; margin: 0;">Applicant's Signature</p>
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<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> <p style="text-align: center; margin: 0;">Date</p>
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9. CONDITIONAL RECEIPT

IMPORTANT: This receipt must not be detached unless settlement toward the first premium has been made at the time of application.

Received from _____ the sum of \$ _____ paid at the time the application is signed and dated this date for a policy or policies of insurance.

In such application _____ is named the proposed customer (policyholder).

Wisconsin Physicians Service Insurance Corporation acknowledges receipt of payment subject to the following conditions:

- A.** If WPS determines, in accordance with established underwriting rules and practices in effect on the date of this receipt, that the applicant is insurable for some or all of the coverages applied for, WPS will issue a policy or policies providing coverage to the extent permitted by such rules and practices, and with the premium determined accordingly.
- B.** The effective date of any policy issued will be the first of the month following approval by WPS. If, however, any policy issued is not accepted upon delivery (such acceptance to include simultaneous payment of excess of the correct initial premium over the portion of the above sum applicable to such policy), the policy will be deemed void from the beginning.
- C.** WPS will return the excess, if any, of the above sum over the sum of the correct initial premium for any policy(ies) issued and accepted.

Writing Agent (Print Name)	Signature of Writing Agent	Date	License No.
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Agency Name	Agency No.
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IMPORTANT: No agent has the authority to modify any provisions of this receipt. This receipt is issued on the condition that any check, draft or other order for payment to WPS be good and collectable.

Note: If you don't receive a policy, or your money is not returned within six weeks from the date of this receipt, please notify WPS in writing at the address shown on this receipt. Please include the amount paid, date of payment, and name of person to whom it was paid.



1717 W. Broadway-P.O. Box 9
Madison, WI 53701-0009

CREDIT/DEBIT CARD AUTHORIZATION FORM

APPLICANT INFORMATION

Last Name _____ First Name _____

WPS Customer Number _____

BILLING INFORMATION, IF DIFFERENT THAN APPLICANT

Name as it Appears on Credit/Debit Card _____

Mailing Address _____

City _____ State _____ Zip Code _____

Country _____

PREMIUM PAYMENT MODE

Select One: Initial Premium Deposit Only Initial Premium and Recurring (Please select a day from the 7th through 31st of a month for payment pull) _____

Note: Recurring premium payments will be charged to your credit/debit card on the day of the calendar month immediately preceding the premium due date, based on your selection. Recurring days available are the 7th through the 31st of the month. If a month does not contain the day you selected, payment will be pulled from your credit/debit card account on the last day of that month. We will continue to charge premiums until the policyholder notifies us to discontinue charging premiums in accordance with the WPS policy.

CREDIT/DEBIT CARD AUTHORIZATION

Select One: Visa MasterCard Discover Card

_____/_____
Credit/Debit Card Number Card Expiration Date
Must be from a personal account

FINANCIAL INFORMATION

I hereby authorize WPS Health Insurance (WPS) or its authorized credit/debit card transaction agent(s) to bill my credit/debit card account indicated above for payment of premiums charged for the WPS insurance policy for which I'm applying. If that WPS individual policy is issued to me by WPS, I understand and agree that by executing this authorization, that action doesn't affect, waive, or change any of the policy's terms, conditions, and provisions, including that policy's premium payment and grace period provisions. I am attesting the credit/debit card listed above is a personal account; I understand the premium may not be paid from a business account.

Sign Here  **X** _____
Applicant's Signature

Date

AUTOMATIC WITHDRAWAL PAYMENT AUTHORIZATION FORM

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments from the account designated below. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify WPS in writing of its termination. My notification must afford WPS and my financial institution reasonable opportunity to act on it.

A. ACCOUNT HOLDER INFORMATION

Name _____ WPS Customer No. (if available) _____

Address _____

City _____ State _____ Zip Code _____

Social Security Number _____

Payment Mode

Select One: Monthly Quarterly Semiannually Annually

B. FINANCIAL INSTITUTION INFORMATION

Institution Name _____ Branch/Location _____

Address _____

City _____ State _____ Zip Code _____

Select One: Checking Account* Savings Account

Please indicate the date in which you wish to have your premium payment withdrawn from your account _____

Transit Number _____ Account Number _____

***IF USING A CHECKING ACCOUNT, PLEASE ATTACH A CHECK WITH "VOID" WRITTEN ACROSS IT.**

Sign Here  **X** _____
Applicant's Signature

Date

FINANCIAL INFORMATION

