SECTION 4 – HEALTH HISTORY

THIS SECTION MUST BE COMPLETED BY APPLICANT

IF APPLYING DURING THE OPEN ENROLLMENT PERIOD OR IF YOU ARE A GUARANTEED ISSUED ELIGIBLE PERSON, DO NOT COMPLETE THIS SECTION (Skip to Section 5)

If the answer to any of the following questions is "Yes", you are not eligible for coverage.
Check the box next to any conditions that apply to you.

	Yes	No
1. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair, cane or walker for any daily activity?	☐	☐
2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer?	☐	☐
3. Within the past 2 years, have you been advised to have surgery which has not yet been done?	☐	☐
4. Within the past 5 years, have you ever consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:		
a. Heart or vascular conditions including but not limited to heart attack, open heart surgery, placement of a stent, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, peripheral vascular disease, coronary artery disease, irregular heartbeat or stroke?	☐	☐
b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder, any neurological disorder or other senility disorder?	☐	☐
c. Any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, emphysema or use of inhalers, nebulizers or oxygen?	☐	☐
d. Internal cancer, leukemia, melanoma, Hodgkin's disease, insulin dependent diabetes, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea) or amputation?	☐	☐
5. In the past 12 months have you had placement of a pacemaker or had a joint replacement?	☐	☐

✳ **Applicant's Initials:** _____

TOBACCO USAGE

Have you used any form of tobacco within the past 5 years? ☐ Yes ☐ No

I acknowledge that misrepresentation of this information may render the policy null and void.

Date:_____ _____
Applicant's Signature

SECTION 5 – MEDICAL INFORMATION

Name of Primary Care Physician _____Telephone (_____)_____

Address _____

SECTION 6 – GENERAL INFORMATION

ANSWER ALL QUESTIONS IN THIS SECTION TO THE BEST OF YOUR KNOWLEDGE

Did you turn age 65 in the last 6 months? ☐ Yes ☐ No

Do you meet the definition of an Eligible Person as defined in this application? ☐ Yes ☐ No

Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

If yes, what is the effective date? _____

Are you covered for medical assistance through the state Medicaid program? {NOTE: 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; will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

If yes; do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ Yes ☐ No