Avalon® Secure Medically Underwritten 2010 Standardized Medicare Supplement Plans Enrollment Application and Change Form

Dear Applicant,

Thank you for your interest in our Avalon Secure Medicare Supplement coverage. We appreciate the opportunity to become your health insurer of choice.

This Enrollment Application and Change Form is for the medically underwritten program, meaning that we examine your personal health history as part of the application process. This allows us to determine your suitability for the product and to help maintain affordable premiums for you and other customers. We may need to obtain additional health-related information from you as part of the underwriting process.

PLEASE READ:

Instructions for completing the Enrollment Application and Change Form are included with each section. To avoid delays in processing your request, please ensure that required information is completed.

A material misrepresentation of facts may lead to higher rates, cancellation, or voidance of coverage.

GENETIC INFORMATION: WHEN ANSWERING SECTION 2a, YOU SHOULD NOT INCLUDE ANY GENETIC INFORMATION. GENETIC INFORMATION IS DEFINED AS ANY FAMILY MEDICAL HISTORY OR ANY INFORMATION RELATED TO GENETIC TESTING, GENETIC SERVICES, GENETIC COUNSELING, OR GENETIC DISEASES FOR WHICH YOU BELIEVE YOU MAY BE AT RISK. THE TERM "FAMILY MEDICAL HISTORY" DOES NOT INCLUDE ANY MEDICAL HISTORY OF ANY INDIVIDUAL APPLYING FOR COVERAGE.

Health Status: Unless exempt, as set forth in Section 2a, you must answer the health status question, marking **YES** or **NO** and completing required fields. Please verify the accuracy and completeness of the answer since erroneous or incomplete application information could jeopardize your coverage or a claim.

NEXT STEPS

We will review your enrollment application and make the determination to approve or decline it. All details of our review will be kept confidential. If your enrollment application is approved, you will receive an approval letter. If your enrollment application is declined, you will receive a declination letter.

QUESTIONS

If you have any questions and/or need help filling out this enrollment application, please contact us at **866.267.9874**.

Avalon Secure Medically Underwritten 2010 Standardized Medicare Supplement Plans Enrollment Application and Change Form

Avalon Insurance Company
PO Box 772612
Harrisburg, PA 17177-2612
866.267.9874

Please check one.

Apply for coverage	❑ →	Complete the entire application and return to Avalon® Insurance Company.
Note: If you are replacing existing Medicare supplement or Medicare Advantage coverage, also complete a replacement notice, returning both the application and replacement notice to Avalon Insurance Company.		
Change your coverage	❑ →	Complete the entire application and replacement notice and return to Avalon Insurance Company.
Change your personal information	❑ →	Complete section 2, go to section 9, sign and date, and return to Avalon Insurance Company.
Cancel your coverage	❑ →	Complete section 11 and return to Avalon Insurance Company.

Use only blue or black ink. Please print clearly.

OFFICE USE ONLY
00900027 Effective Date: _____

1. Select Your Plan

Instructions: Select only one plan. Refer to the Outline of Coverage for rates and benefit information.
Plan A ❑ Plan B ❑ Plan G ❑ Plan N ❑

You may also select one of the following if you were **first** eligible for Medicare prior to 01/01/2020: Plan C ❑ Plan F ❑

2. Tell Us About Yourself

Applicant information: This section **MUST** be completed in full. Please print clearly to avoid any delay in processing your application.

Health Insurance Information (MEDICARE): Refer to your Medicare Card (red, white, and blue health insurance card) to complete section 2.

If you are submitting the application as an "Authorized Representative" or Power of Attorney, please include an authorization form with the completed application.

PLEASE PRINT

Name of Beneficiary (Last) (First) (MI)

Street Address (Billing and Mailing Address)

City State ZIP

County of Residence Daytime Phone No. ( )

Birth Date (MM/DD/YYYY) Social Security Number

Male ❑ Female ❑ Would you care to share your email address with us? If so, please enter below.

Medical Health Insurance Claim No. (as found on your Red, White, and Blue Medicare ID Card)

Is entitled to: Hospital Insurance ❑ Hospital Insurance Part A Effective Date (MM/DD/YYYY) _____
Medical Insurance ❑ Medical Insurance Part B Effective Date (MM/DD/YYYY) _____

If you are within six months of turning age 65, or within six months of enrolling in Medicare Part B or, if you qualify for a Guaranteed Issue Right, as outlined in Section 4 of this application, you do not need to complete this section. Please proceed to Section 3.

Health Status: All questions must be answered before the enrollment application can be processed. When answering questions, you should not include any genetic information. See the first page for the definition of genetic information.

NOTE: If there is a change in your health status regarding any of the items below, after you have completed your enrollment application but, before your effective date, you must notify us immediately at PO Box 772612, Harrisburg, PA 17177-2612 or 866.267.9874. A change in health status that occurs before your effective date could jeopardize your coverage or a claim.

Please mark **YES** or **NO** below with an "**X**."

	Are you disabled?	YES ❑	NO ❑
	Have you used tobacco products in the last 12 months?	YES ❑	NO ❑
	Have you been medically diagnosed and/or advised by a member of the medical profession that you have End Stage Renal Disease (ESRD)?	YES ❑	NO ❑
	Have you been medically diagnosed and/or advised by a member of the medical profession, within the past five years, that you have kidney disease requiring dialysis, or are you currently receiving dialysis?	YES ❑	NO ❑
	Have you received a bone marrow or organ transplant in the last five years?	YES ❑	NO ❑
	Have you been advised by a member of the medical profession, within the past 24 months, that you will require a bone marrow or organ transplant?	YES ❑	NO ❑
	Are you currently:		
2a.	Hospitalized	YES ❑	NO ❑
	Residing in a skilled nursing facility or nursing home	YES ❑	NO ❑
	Enrolled in a hospice program	YES ❑	NO ❑
	Has a physician recommended that you enter a hospital or a skilled nursing facility within the next six months?	YES ❑	NO ❑
	Have you had a joint replacement in the past 12 months or been recommended to have a joint replacement in the next 12 months?	YES ❑	NO ❑
	Have you been medically diagnosed and/or advised by a member of the medical profession, or have you received treatment, for AIDS (Acquired Immune Deficiency Syndrome), HIV (Human Immunodeficiency Virus), or AIDS Related Complex?	YES ❑	NO ❑
	Have you been medically diagnosed with diabetes within the last 24 months, or are you being treated with insulin, or has your medication changed within the past 12 months?	YES ❑	NO ❑
	Are you confined to a wheelchair or use a walker?	YES ❑	NO ❑
	Have you been medically diagnosed or treated for any brain disorder, brain trauma, or brain injury, including but not limited to, epilepsy, septicemia, psychosis, manic depression, narcolepsy, encephalitis, or post traumatic stress disorder?	YES ❑	NO ❑
	Have you been medically diagnosed and/or advised by a member of the medical profession, or have you received treatment, for any of the following diseases or conditions within the past five years?		
	Alcohol and/or Chemical Dependency	YES ❑	NO ❑
	Alzheimer's Disease, Parkinson's Disease, Dementia, Multiple Sclerosis (MS), or Amyotrophic Lateral Sclerosis (ALS, Systemic Lupus Erythematosus [SLE])	YES ❑	NO ❑
	Aplastic Anemia, Cooley's Anemia, Hemolytic Anemia, or Hemophilia	YES ❑	NO ❑
	Arteriosclerosis or Atherosclerosis	YES ❑	NO ❑
	Barrett's Esophagus, Chronic Pancreatitis, Ulcerative Colitis, Esophageal Varices, or Crohn's Disease	YES ❑	NO ❑

Bipolar Disease or Schizophrenia YES ❑ NO ❑

Cancer (other than skin cancer), Leukemia, Lymphoma, or Melanoma YES ❑ NO ❑

Heart conditions, including Coronary Artery Disease (CAD), Heart Attack, Congestive Heart Failure (CHF), Atrial Fibrillation (A-Fib), Stroke, Transient Ischemic Attack (TIA), Aneurysm, Cardiomyopathy, or an artery or vein blockage YES ❑ NO ❑

Herniated disc, degenerative disc disease, degenerative joint disease, or spinal stenosis YES ❑ NO ❑

Hodgkin's Disease YES ❑ NO ❑

Liver disorders including cirrhosis of the liver or chronic hepatitis YES ❑ NO ❑

Lung conditions, including Chronic Obstructive Pulmonary Disease (COPD), Emphysema, or use of supplemental oxygen YES ❑ NO ❑

Macular Degeneration YES ❑ NO ❑

Myasthenia Gravis YES ❑ NO ❑

Osteoporosis with one or more compression fractures in the last five years YES ❑ NO ❑

Paraplegia or Quadriplegia; unable to move your arms and/or legs YES ❑ NO ❑

Psoriatic Arthritis or Rheumatoid Arthritis YES ❑ NO ❑

Weight Loss Surgery YES ❑ NO ❑

Do you need assistance performing any of the following daily activities:

Eating/Feeding *(condition/reason: _____)* YES ❑ NO ❑

Bathing/Dressing *(condition/reason: _____)* YES ❑ NO ❑

Toileting *(condition/reason: _____)* YES ❑ NO ❑

Hygiene/Grooming *(condition/reason: _____)* YES ❑ NO ❑

Mobility, including transfers *(condition/reason: _____)* YES ❑ NO ❑

2a. cont.

Height: _____ ft. _____ in. Weight: _____ lbs.

Please list any medications that you are currently taking, or have taken in the last 12 months, or medications that have been prescribed in the last 12 months:

Name of Drug	Prescribing Physician	Condition	Currently Taking (Yes/No)

Please list any supplements or vitamins that you are currently taking or have taken in the last 12 months:

Name of Vitamin or Supplement	Currently Taking (Yes/No)

Please complete the following information for therapies prescribed:

Therapy	Condition Treating	Currently Attending (Yes/No)	Attended in last 12 months	Recommended for future (Yes/No)
Physical				
Occupational				
Speech				

Please Read, Sign, and Date Below

2b.

Disclosure Agreement

So that Avalon Insurance Company may obtain the information it needs (i) to determine whether I am eligible to enroll, (ii) to determine the premium to charge me if I am eligible, and (iii) to determine the appropriate treatment of claims once I enroll, by signing this form I authorize the following entities to use and disclose any individually identifiable health information about me that they have for the following purposes:

A consumer reporting agency for the purposes of (i) developing a report summarizing health conditions I may or am likely to have and (ii) providing that report to Avalon Insurance Company; and

My current and former health care providers, insurers (or health plans), and their vendors (such as pharmacy benefit managers) for the purpose of providing the health history information to Avalon Insurance Company.

I understand the nature of this release and that information affected by this authorization may include information protected by state law including, but not limited to, information about HIV status, mental health conditions, and substance abuse issues. This form does not apply to and I do not authorize disclosure of psychotherapy notes.

I understand that Avalon Insurance Company may refuse to enroll me, unless I sign this form. I understand that I may revoke this authorization at any time by sending written notice to Avalon Insurance Company at:

Privacy Officer
Avalon Insurance Company
PO Box 772132
Harrisburg, PA 17177-2132

My revocation will not affect the rights of anyone who has acted in reliance on the authorization prior to receiving the notice of revocation. Unless revoked earlier, this authorization will be valid until six months after termination of enrollment with Avalon Insurance Company. I understand that the information covered by this form, once disclosed, may be further used and disclosed by Avalon Insurance Company as permitted by Federal and State law and, if disclosed to another entity, may no longer be protected by federal rules governing privacy and confidentiality.

SIGNATURE _____ DATE _____

Please Read for Important Information

3.

1. **Statements**

   i. You do not need more than one Medicare supplement policy.

   ii. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

   iii. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

   iv. 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 the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

   v. 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

   vi. 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).

2. **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 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.

4.

For a Medicare Eligible enrolled in Medicare Part B for six (6) months or more, the Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 provide set categories which guarantee health insurance coverage without preexisting condition waiting periods.

In some situations, you have a guaranteed issue right to purchase Medicare supplement coverage. If you are not within your Open Enrollment Period[1], you may be able to obtain health insurance coverage without a preexisting condition limitation if you: (a) have Medicare Part A and Part B, (b) reside in our service area, (c) do not have group health coverage, (d) apply for this coverage within 63 days from the date your previous coverage was terminated, and (e) fall within one of the following categories:

1. Your employer group health benefit plan was: (a) coverage that supplemented (i.e., was in addition to) Medicare and was terminated by the employer, or (b) coverage that paid before Medicare and was terminated by you or the employer.

2. Your previous insurance company ended its Medicare Advantage coverage (a managed health care plan that replaces Medicare Part A and Part B benefits), Medicare SELECT coverage (a type of Medigap policy that may require you to use doctors and hospitals within its network to be eligible for full benefits), Medicare PACE[2] coverage, or you moved out of that Plan's service area.

3. You left Medicare Advantage/Medicare SELECT/ Medicare PACE[2], or left other Medicare supplement coverage because your insurer is bankrupt, did not follow an important provision of your policy (i.e., which guarantees health insurance availability without preexisting condition waiting periods), or your policy was misrepresented to you when you purchased it.

4. You cancelled Avalon Secure's coverage to join a Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan. However, you now wish to terminate that coverage and return to Avalon Insurance Company's coverage. You must reapply within 12 months of the date you terminated your coverage, and you may apply for the plan in which you were originally enrolled or for a lower cost plan.

5. You cancelled Medicare supplement coverage to join a Medicare Advantage/Medicare SELECT/ Medicare PACE[2] plan. However, within 12 months of joining, you chose to terminate coverage with the Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan and return to your Medicare supplement coverage. You may apply for coverage only if the Medicare supplement coverage which you previously had with your prior insurer is no longer available.

6. You joined a Medicare Advantage/Medicare SELECT/Medicare PACE[2] plan when you were first notified of your eligibility for Medicare. However, within 12 months of joining that plan, you decided to terminate that coverage and enroll in Avalon Insurance Company's coverage.

7. Your Medicare Advantage Plan has withdrawn from a service area. If you decide to leave the Medicare Advantage Plan prior to the termination date, you have 63 days from the date of your final notification letter to apply for coverage. If you decide to stay enrolled in a Medicare Advantage Plan until the contract terminates, you have 63 days from the date your coverage terminates under the Medicare Advantage Plan to apply for Avalon Insurance Company's coverage.

Note: You have 63 days from the date that your previous coverage terminated to apply for coverage. Eligible persons are permitted by law to enroll in Plans A, B, G, and N. If you were **first** eligible for Medicare prior to 01/01/2020, you are also eligible to enroll in Plans C and F.

If you feel you are qualified for any of the above categories, please provide the following information when submitting your application. May require additional documentation.

Name	ID #	Category to which you belong (1-7 above)#

[1]Open Enrollment Period is the six-month time period after first enrolling in Medicare Part B, or reaching the age of sixty-five (65), in which an individual may enroll for *Medicare supplement* coverage.

[2]Medicare PACE refers to the federal Program for All-Inclusive Care of the Elderly and is not affiliated with the Pennsylvania PACE, Pharmaceutical Assistance Contract for the Elderly.

PLEASE ANSWER ALL QUESTIONS

5. Tell Us About Your Medicare Coverage *Please mark YES or NO below with an "X"*

To the best of your knowledge,

Did you turn age 65 in the last six months? YES ❑ NO ❑

Did you enroll in Medicare Part B in the last six months? YES ❑ NO ❑

If **YES**, what is the effective date (MM/DD/YYYY)? _____

6. Tell Us About Any Medicaid Coverage (if applicable) *Please mark YES or NO below with an "X"*

To the best of your knowledge,

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 towards your Medicare Part B premium? YES ❑ NO ❑

7. Tell Us About Any Other Medicare Coverage

To the best of your knowledge,

If you had any coverage from any Medicare plan other than the original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START (MM/DD/YYYY) _____ END (MM/DD/YYYY) _____

8. Tell Us About Any Other Health Insurance Coverage

To the best of your knowledge,

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 ❑

Was this your first time in this type of Medicare plan? YES ❑ NO ❑

Did you drop a Medicare supplement policy to enrollment in the Medicare Plan? YES ❑ NO ❑

Do you have another Medicare supplement policy in force? YES ❑ NO ❑

If so, with what company? _____

What plan do you have?

Plan A ❑ Plan B ❑ Plan C ❑ Plan D ❑ Plan F ❑ Plan G ❑ Plan K ❑ Plan L ❑ Plan M ❑ Plan N ❑

If so, do you intend to replace your current Medicare supplement policy with this policy? YES ❑ NO ❑

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) YES ❑ NO ❑

If so, with what company and what kind of policy? _____

What are your dates of coverage under the policy? (If you are still covered under the other policy, leave "END" blank.)

START (MM/DD/YYYY) _____ END (MM/DD/YYYY) _____

Read and Sign Below to Complete Your Application

Please read this section very carefully. After you read and understand this section, please sign and date your application.

Note: If coverage is desired for your spouse, please have him/her complete a separate application. Applications are available through our Medicare Sales Department at **866.267.9874**.

This plan will not, during the first six months of coverage, provide benefits for services related to any conditions for which advice or treatment was received from a physician within the last six months prior to enrollment. You can reduce or eliminate your preexisting condition waiting period if you had other basic coverage that ended within the past 63 days.

To Avalon Insurance Company:

9. I hereby apply for the coverage indicated and acknowledge receipt of the Outline of Medicare Supplement Coverage and Guide to Health Insurance for People with Medicare provided with this application. This plan will not, during the first six months of coverage, provide benefits for services related to any condition of which advice or treatment was received from a physician within the last six months prior to enrollment unless creditable or replacement coverage is applicable. I understand this application is subject to approval by the insurer and any coverage will be subject to the terms of the contract issued to me. I understand that if approved, I may not be permitted to change the plan (A, B, C, F, G, or N) which I selected, except during an open enrollment period. I may move to a plan with lower coverage for benefits at any time. I verify that the information supplied by me is correct to the best of my knowledge, information, and beliefs. If I am replacing Medicare supplement or Medicare Advantage coverage, I have also read and understood the Replacement Notice. 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 materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

SIGNATURE _____ DATE _____

To be Completed by Insurance Producer or Other Representative

10.

Policies sold which are still in force

Policies sold in the past five years which are no longer in force

Name of Issuer, Producer, or Other Representative

Address of Issuer, Producer, or Other Representative	Preferred Agency
Producer ID	Signature of Producer or Other Representative

Cancel Your Coverage

I hereby authorize Avalon Insurance Company to cancel my coverage. I understand the effective date of the changes will be determined by Avalon Insurance Company.

11. Reason for cancellation: _____

ID Number: _____

SIGNATURE _____ DATE _____