

**PHILADELPHIA AMERICAN LIFE INSURANCE COMPANY**  
**APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE**

For Seniors with Medicare Parts A and B



**Section 1 – Choice of Coverage**

Please check the box for your choice of coverage:

- Standard Plan A     Standard Plan C     Standard Plan F     Standard High  
 Standard Plan B     Standard Plan D     Deductible Plan F

**Section 2 – Application Information**

This complete original application will be returned to you, for your records, along with your policy, when you are enrolled.

Please copy the information from your Medicare card here



NAME OF BENEFICIARY (Applicant)	CLAIM NUMBER	SEX
_____	_____	_____
IS ENTITLED TO	EFFECTIVE DATE	
HOSPITAL INSURANCE	_____	
MEDICAL INSURANCE	_____	

Requested effective date, or end date of prior Medicare supplement, if replacing \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name (as it appears on your Medicare card) \_\_\_\_\_

Social Security Number 

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 Date of Birth \_\_\_\_\_

Home Address, Apt. No., Suite No. \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Telephone Number \_\_\_\_\_

Billing Address, (if different from home address) \_\_\_\_\_

City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Care of/Attention \_\_\_\_\_

**Section 3 – Billing Information**

- Quarterly     Bimonthly     Monthly (Checking Account Deduction Only)

<b>Philadelphia American Use Only</b>	
Broker Number	_____
H/S	<input type="checkbox"/> Yes <input type="checkbox"/> No
Amount Received \$	_____
Policy No.	_____
Effective Date	_____

*Affix check here. Please make check or money order for premium payable to Philadelphia American Life Insurance Company.*

**No agency checks are accepted.**

**Applicant: Please return application to agent or to the mailing address below:**

Philadelphia American Life Insurance Company, Underwriting Department  
P.O. Box 4884  
Houston, Texas 77210-4884

## Section 4 – Health History

**THIS SECTION MUST BE COMPLETED BY APPLICANT**  
IF APPLYING DURING THE OPEN ENROLLMENT PERIOD,  
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 for any daily activity?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 2 years, have you been advised to have surgery which has not yet been done?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past 5 years, have you ever experienced, been told you had, 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 conditions including but not limited to heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, stroke?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer’s disease, Parkinson’s disease, senile dementia, organic brain disorder, or other senility disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. any respiratory condition including but not limited to Chronic Obstructive Pulmonary Disease (COPD), asthma, or emphysema (excluding allergies)?   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. internal cancer, leukemia, 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), amputation or joint replacement due to disease?   | <input type="checkbox"/> | <input type="checkbox"/> |

Applicant’s Initials \_\_\_\_\_

## Section 5 – Medical Information

Name of Primary Care Physician \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_

## Section 6 – General Information

ANSWER ALL QUESTIONS IN THIS SECTION

Do you have another Medicare supplement insurance policy, certificate, or coverage in force?  Yes  No

If so, with which company? \_\_\_\_\_

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

Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare supplement policy?  Yes  No

If so, with which company? \_\_\_\_\_ What kind of policy? \_\_\_\_\_

Are you covered for medical assistance through the state Medicaid program?  Yes  No

If so, as a Specified Low-Income Medicare Beneficiary (SLMB)?  Yes  No

If so, as a Qualified Medicare Beneficiary (QMB)?  Yes  No

If so, for other Medicaid medical benefits?  Yes  No

### 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 7 – Conditions of Application

Please read the following carefully.

1. I agree to submit the premium required for the plan requested with this application. Such premium will be returned to me if my application is rejected or if I decide to cancel the policy within the first thirty (30) days. If my application is accepted, the amount paid will be applied to the premium.
2. Philadelphia American will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B. If my application is not received during the open enrollment period, Philadelphia American has the right to reject my application. If Philadelphia American rejects my application, I will be notified in writing and the premium submitted with this application will be refunded. I understand and agree that if Philadelphia American rejects my application, under no circumstances will any Philadelphia American benefits be payable. ***Cashing of my check by Philadelphia American does not constitute approval of my application.***
3. If my application is accepted, this application will become part of the agreement between Philadelphia American and myself.
4. The selling agent has no authority to promise me coverage or to modify Philadelphia American underwriting policy or terms of any Philadelphia American coverage.
5. I have read and accurately completed this application. To the best of my knowledge I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that Philadelphia American may void all coverage from the original effective date of the policy for material misstatements or omissions.

## Section 8 – Authorization and Agreements

### Notice to Applicant

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to our Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. 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).

### Authorization To Obtain or Release Medical Information – You Are Entitled To A Copy of This Signed Authorization Form For Your Files If Requested. (Read all five paragraphs and sign below)

- I hereby authorize the U.S. Department of Health and Human Services (including the Health Care Financing Administration and any contractors or agents, including Medicare intermediaries), any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish an agent, designee, or representative of Philadelphia American Life Insurance Company any and all records pertaining to claims payments or rejections, medical history, services rendered, or treatment given to anyone enrolled hereunder or added hereafter for purposes of review, investigation, or evaluation of an application or a claim.
- I also authorize Philadelphia American, or its agents, designees or representatives to disclose to a hospital or health care service plan, self-insurer, or insurer any such medical information obtained if such a disclosure is necessary to allow the processing of any claim.
- This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Philadelphia American to process claims. A photocopy shall be valid.
- I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), the Conditions of Application and the Authorization. I acknowledge receipt of the “Guide to Health Insurance for People with Medicare,” and “Outline of Medicare Supplement Coverage and Premium Information” as required. I understand that receipt of money with this application does not create Philadelphia American coverage. Coverage will come into effect only if this application is approved by Philadelphia American.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety and realize that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

X

Applicant's Signature

X

Date of Signature

**For Agent Only**

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force, and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr. _____	_____	Name: _____
To: Mo./Yr. _____	_____	Address: _____
		City/State: _____

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

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**SIGNED AT**

Agent's Signature _____	Date of Signature _____	(City and State) _____
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Print Agent's Name _____	Agent No. _____
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Street Address _____	Telephone No. _____
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City _____	State _____	ZIP _____
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Premium Amount \$ \_\_\_\_\_

Send Policy To:    Agent    Insured

*The I.D. Card will be sent to the agent or insured in a separate mailing.*

**Senior Services Toll-Free Number**  
 Monday-Friday: 8:00 a.m. to 5:00 p.m. (Central Standard Time)  
 (877) 368-4691