SecureHorizons®
from PacifiCare®

Application for Secure Horizons Medicare Supplement* Plan

CA

Personal Information

FOR OFFICE USE ONLY:
Group Number: ________ Plan Code: ________
Benefit Class: ________ Batch: ________
Premium: ________ Attachment: ________

Please Check Plan Desired:

☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan G

Requested Effective Date ______/ 1 /______ (MONTH DAY YEAR) Do you use tobacco products? ☐ Yes ☐ No

Social Security Number |______|_____|________| Sex ☐ Date of Birth ______/___/_____ (MONTH DAY YEAR)

First Name ____________________ Middle Initial ________ Last Name ____________________

Residential Mailing Address ____

Residential City ____________________ Residential State ________ Residential Zip ________

Residential Telephone (____) ____________________ E-mail Address ____________________

Billing Address (if different from above) ____

Billing City ____________________ Billing State ________ Billing Zip ________

Medicare Information – From your red, white and blue Medicare Card

Name of Beneficiary (if different than applicant) ____________________

Medicare Number |______|_____|________|__|

Is entitled to: Hospital (Part A) Effective Date ________ Medical (Part B) Effective Date ________

Current Health Coverage Information

Please answer the following questions, to the best of your knowledge:

1. ☐ Yes ☐ No Do you have another Medicare Supplement policy or certificate in force, including an HMO contract?
   If yes to 1., with which company? ____________________
   ☐ Yes ☐ No If yes to 1., do you intend to replace your current Medicare Supplement policy with this policy or certificate?
2. ☐ Yes ☐ No Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy?
   If yes to 2., with which company? ____________________
   If yes to 2., what kind of policy? ____________________
3. ☐ Yes ☐ No Would the benefits duplicate the benefits in this Medicare Supplement policy?
4. ☐ Yes ☐ No Are you covered for medical assistance through the Medi-Cal program?
   - ☐ Yes ☐ No As a Specified Low-Income Medicare Beneficiary (SLMB)?
   - ☐ Yes ☐ No As a Qualified Medicare Beneficiary (QMB)?
   - ☐ Yes ☐ No For other Medi-Cal medical benefits?

Statement of Health

If you qualify for guaranteed issue coverage (see Guaranteed Issue Guide section), please answer the following questions:

What situation do you qualify for under guaranteed issue?__________(Number of Situation)

Please include a copy of the required documentation with this application.

*Underwritten by PacifiCare Life and Health Insurance Company

Statement of Health (continued)

Please complete only if you do not qualify for guaranteed issue coverage.

Height ______ft. ______in. Weight ______lbs.

1. Have you ever been diagnosed or treated by a licensed health care professional for any of the conditions below?

☐ Yes ☐ No Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?

☐ Yes ☐ No High blood pressure, heart disease, heart attack, chest pain, disorder of heart valves, or any other cardiac or peripheral vascular related disorder?

☐ Yes ☐ No Stroke, seizures, diabetes?

☐ Yes ☐ No Cancer, tumor, growth, paralysis, arthritis, mental disorder?

☐ Yes ☐ No Disease/disorder of liver, thyroid, lungs, kidneys, urinary tract, digestive system, central nervous system, reproductive organs, back, bone or joints?

☐ Yes ☐ No Any disease or disorder not mentioned above?

If you answered yes to any of the above questions, please complete the following. If additional space is needed, attach a separate sheet of paper. Sign and date all separate sheets.

Disease/Disorder	Date Treated	Treatment	Current Condition	Physician Name	Physician Phone

2. ☐ Yes ☐ No Have you had heart surgery (including angioplasty), pacemaker, artificial heart valve, or transplant surgery?

If yes, please explain condition. ______________________________

______________________________ Date of Surgery ______________

3. ☐ Yes ☐ No Have you been bedridden or confined to a hospital, nursing home, skilled nursing facility, or other institution within the past three years?

If yes, please explain condition. ______________________________

______________________________ Date of Confinement ______________

4. ☐ Yes ☐ No Have you ever been advised to have an operation or treatment that has not yet been performed (including dental work)?

5. ☐ Yes ☐ No Are you currently taking any medications?

Please List Medications	Please Explain Condition

6. ☐ Yes ☐ No Have you used tobacco products in the past 5 years? If yes, please provide the following information:

Start Date __________ Stop Date __________ Daily Amount __________

(Customer must return White Copy with premium payment) Yellow - Applicant Copy White - Enrollment Copy

Conditions of Eligibility and Authorization

Before you apply, it is important that you read the following eligibility information and statements, then sign and date below in the required place:

1. You do not need more than one Medicare Supplement policy.
2. If you purchase a Medicare Supplement plan, you may want to evaluate your existing health coverage to decide if you need multiple coverages.
3. You may be eligible for benefits under Medi-Cal 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 Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your policy will be reinstated, if requested, within 90 days of losing Medi-Cal eligibility.
5. Counseling services may be available in your area to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance toll-free telephone number, 1-800-510-2020, and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the state of California. A rate guide is available that compares the policies sold by different insurers.

   You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free telephone number (1-800-927-HELP), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Insurance's Internet web site (www.insurance.ca.gov).
6. This application will become part of the policy for which you are applying.
7. You will receive no coverage under this plan unless Secure Horizons Underwriting Department approves this application. Secure Horizons is not liable for bills incurred before the effective date of coverage. Cashing of your check does not constitute approval of your application.
8. Only Secure Horizons can approve this application. A sales representative cannot grant approval, change terms, or waive requirements.
9. **California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**
10. Authorization for Disclosures of Personal Information: I authorize any "provider of care," insurer, or health plan to disclose to Secure Horizons, or their representatives, all "medical information" (as those terms are defined in the California Civil Code) regarding me, including medical information regarding substance abuse or mental/ emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review. This authorization is effective immediately and shall remain for a period of thirty months, except that it shall remain effective for use with any claim for benefits for as long as Secure Horizons coverage is in effect. A photocopy of this authorization is as valid as the original. My authorized representative and I are entitled to receive a copy of this authorization.

I HAVE READ THE OUTLINE OF COVERAGE AND CONDITIONS. I UNDERSTAND AND AGREE TO THEM. I ALONE AM RESPONSIBLE FOR THE ACCURACY AND COMPLETENESS OF THIS APPLICATION FOR HEALTH COVERAGE. I UNDERSTAND THAT I WILL NOT BE ELIGIBLE FOR COVERAGE IF ANY INFORMATION IS FALSE OR INCOMPLETE, AND THAT COVERAGE MAY BE REVOKED BASED ON SUCH FINDINGS.

I UNDERSTAND THE ELIGIBILITY INFORMATION AND HAVE ANSWERED THE QUESTIONS IN THIS APPLICATION TO THE BEST OF MY KNOWLEDGE. I CERTIFY THAT I MEET THE ELIGIBILITY REQUIREMENTS OUTLINED. I HAVE ALSO RECEIVED AN OUTLINE OF COVERAGE AND A COPY OF THIS APPLICATION.

Applicant's (or Legal Guardian's) Full Signature ______________________________

Applicant's Full Name (Please Print) ______________________________ Date__________

Agent Information — List the Following:

Any other health insurance policies or coverages sold to the applicant which are still in force: ______________________________

Any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force: ______________________________

If the applicant is applying for one of the Medicare Supplement Plans, I affirm that I have fully explained to the applicant the requirements of using a Secure Horizons participating Medicare Supplement hospital in order to receive coverage for the Medicare Part A deductible. I have also reaffirmed that the information supplied on this application is accurate and complete.

Agent Signature: ______________________ Date Signed: ______________________

Print Name of Agent: ______________________ Agent Code (SS# or Tax ID#): ______________________

Firm's Name (If applicable): ______________________ Phone Number: (____) ______________________

General Agent: ______________________________ (GA Code 2)