MEDAmerica INSURANCE COMPANY
An Excellus Company Home Office: Pittsburgh, PA

[TRANSITIONS™]
Short Term Recovery Care Application
TRS-336-XX
[ER/ASSOC#: _____]

[Administrative Offices:]
[165 Court Street]
[Rochester, NY 14647]
[1-800-544-0327]

I. APPLICANT INFORMATION:

1. IDENTIFYING INFORMATION:

Applicant Name (First, MI, Last)	Social Security Number	Email Address

Legal Residence Street Address (PO Box Not Adequate-Must Provide Street)	Mailing/Delivery Street Address (if different)
City State Zip	City State Zip

Home Phone	Work Phone	Date of Birth	Age	Sex	Marital Status
( )	( )	/ / MM/DD/YYYY		☐ Male ☐ Female	☐ Married ☐ Single ☐ Single with Domestic Partner (*Sign Domestic Partner Statement*)

2. SPOUSE / DOMESTIC PARTNER INFORMATION

Name (First, MI, Last)	Social Security Number
	__ __ __ - __ __ - __ __ __ __

3. ALTERNATE BILLING ADDRESS: Address applicant requests billing be mailed to IF different than above.

Name (First, MI, Last) Phone Number	Street Address City State Zip
( )	

II. INSURABILITY PROFILE-MUST BE COMPLETED BY ALL APPLICANTS (Answer each question, check YES or NO.)

1. Have you had Diabetes, other than diet controlled, for greater than ten (10) years?	☐ YES ☐ NO
2. Do you have any complications of Diabetes including peripheral vascular disease, kidney disease, neuropathy, retinopathy, or amputations?	☐ YES ☐ NO
3. In the past 3 years have you received Medical Advice, Consultation, or Treatment for any of the following: • Alzheimer's Disease, Memory Loss, Dementia, Schizophrenia, Manic-Depression, or Mental Retardation • Amyotrophic Lateral Sclerosis (ALS), Myasthenia Gravis, Multiple Sclerosis or Parkinson's Disease • Muscular Dystrophy, Any Chronic Muscular or Connective Tissue Diseases, or Rheumatoid Arthritis • 2 or more Joint Replacements, 2 or more Fractures, any Spinal Surgery, or any Narcotic or Epidural pain management • Congestive Heart Failure, Cardiomyopathy, Stroke, or Transient Ischemic Attack (TIA) • AIDS, Kidney Disease, Liver Cirrhosis, or Hepatitis (Other than Hepatitis A) • Cancer (Other than Basal or Squamous Cell Skin Cancer), Organ Transplants, or Bone Marrow Transplants • Alcohol abuse, prescription drug abuse, or illegal drug use	☐ YES ☐ NO
4. In the past 3 years have you needed assistance or supervision from another person to eat, bathe, dress, get in or out of a bed or chair, use the toilet, or maintain personal hygiene due to incontinence?	☐ YES ☐ NO
5. In the past 3 years have you used a Wheelchair, Walker, Motorized Scooter, Quad Cane, Dialysis, Catheters, Ventilators, Oxygen, Stairlift, Hospital Bed at Home, or Home Intravenous Medications?	☐ YES ☐ NO
6. In the past 3 years have you been advised to receive Home Health Care, Adult Day Care services or Rehabilitative Services for a period of 6 months or longer, including Physical or Occupational Therapy?	☐ YES ☐ NO
7. In the past 3 years have you been confined to or advised to enter a Nursing Home, Assisted Living Facility, or any other type of Long-Term Care Facility?	☐ YES ☐ NO
8. In the past 3 years have you been advised to be hospitalized or have any surgery that has not yet taken place?	☐ YES ☐ NO
9. In the past 3 years have you qualified to receive federal, state, or local government assistance in any form, such as, Supplemental Social Security Income, Social Security Disability Income, Medicare premiums paid by the state, Medicare due to disability, or Medicaid OR received Worker's Compensation or Long Term Disability benefits?	☐ YES ☐ NO
10. In the past 3 years have you been declined for any long term care insurance?	☐ YES ☐ NO

STOP! **Any Yes Response, we cannot offer coverage at this time. Do not submit the application.**

OFFICE USE ONLY
App. Rec: _____ App Status: _____ UW Date: _____ Init: _____
☐ **Issued** ☐ **Declined** **Effective Date:** _____

III. POLICY BENEFIT SELECTION:

STEP 1: SELECT DAILY BENEFIT AMOUNT: $ _____ *($50 - $300 in $10 increments)*

STEP 2: SELECT BENEFIT PERIOD: ***(Choose One)***	☐ **100 Days**	☐ **200 Days**	☐ **360 Days**
STEP 3: ELIMINATION PERIOD: ***(Choose One)***	☐ **20 Days**	☐ **30 Days**	☐ **60 Days**
STEP 4: INFLATION: ***(Choose One)***	☐ **None**	☐ **5% Simple**	

IV. INSURANCE HISTORY

1. Are you allowing any nursing home (NH), home health care, long term care insurance policy, rider or certificate or any other accident or health insurance policy to lapse or do you intend to replace any other nursing home, home health care, long term care insurance policy, rider or certificate or any other accident or health insurance policy in force with this policy? **If Lapsed, Provide Termination Date. If YES, please provide the following information. (Use extra paper if needed).**

☐ **YES**
☐ **NO**

Company Name	**Address (Street, City, State, Zip)**	**Policy Type:** ☐ Nursing Home ☐ Home Care ☐ LTC ☐ Accident ☐ Health			
In Force ☐ Yes ☐ No	**Policy Number**	**Daily Benefit Amount**	**Years Coverage**	**Effective Date**	**Term Date**

V. PREMIUM PAYMENT INFORMATION: All Applicants must CHOOSE ONE method and complete required information.

1. ☐ **DIRECT BILL**

Select the frequency of your Direct Billing payment

☐ Quarterly

☐ Semi-Annual

☐ Annual

2. ☐ **ELECTRONIC FUNDS TRANSFER (EFT)**

Select the frequency of your EFT payment. Signature required below.

☐ Monthly ☐ Quarterly

☐ Semi-Annual ☐ Annual

_____
Bank Name

_____
Bank Account Number

_____
Routing Number (9 digits)

Requires Minimum of 2 months Conditional Premium. Attach Voided Check if Requesting EFT from Different Bank Account than Conditional Premium Check.

[3. ☐ **CREDIT CARD**

Select the frequency of your Credit Card payment. Signature required below.

☐ Monthly ☐ Quarterly

☐ Semi-Annual ☐ Annual

[☐ **VISA]**

[☐ **MASTERCARD]**

_____
Credit Card Number

_____
Expiration Date MM/YY]

[4) ❑ **Payroll Deduction**

(Must be available through a group program and your employer.)
Signature required below.

I authorize my employer to deduct the applicable premium from my salary.

I authorize MedAmerica Insurance Company to adjust these deductions based on rate changes or changes in coverage to my Policy.

I may revoke this authorization at any time by written notice to my employer and to MedAmerica Insurance Company.

Please attach Payroll stub.]

***Authorization for [EFT, Credit Card and Payroll Deduction]: Required IF Choosing [EFT OR Credit Card] Payment Method**

I authorize my financial institution, credit card company [or employer] as indicated above, to automatically make payments to MedAmerica Insurance Company for my insurance. This authorization shall remain in force until I give notification of termination to my financial institution and MedAmerica Insurance Company in writing.

☞ _____
Account Holder Signature

☞ _____
Joint Account Holder Signature (*only required for joint accounts*)

VII. HIPAA MEDICAL AUTHORIZATION (Uses and Disclosures of Medical Information)
Must be signed by all applicants.

This is a HIPAA compliant authorization. "HIPAA" is the Health Insurance Portability and Accountability Act of 1996, as amended.

I hereby authorize the following uses and disclosures of medical information about me.

From Me. I agree to permit company representatives to contact me to ascertain my health status to determine if my application is accepted.

From My Health Care Providers. I authorize any physician, medical practitioner, hospital, clinic or other health care provider or health related facility, including but not limited to those identified above, insurance or reinsurance company or employer, having information available as to any diagnosis, treatment and prognosis with respect to any of my physical or mental conditions and/or treatments, to furnish MedAmerica Insurance Company and/or designated business associates acting as insurance support organizations on MedAmerica Insurance Company's behalf any such protected health information, which may include my entire medical record, needed to determine my eligibility for insurance. THIS AUTHORIZATION EXPRESSLY INCLUDES INFORMATION ABOUT DRUGS, ALCOHOLISM, MENTAL ILLNESS AND COMMUNICABLE DISEASES. This authorization does not include psychotherapy notes. Regulations require a separate authorization for psychotherapy notes. We will contact you if we determine that such an authorization is needed.

For 24 Months. I agree that this authorization will be valid for 24 months from the date signed below and that a photocopy shall be as valid as this original. You may revoke this authorization at any time by giving written notice of revocation to the [LTC Privacy Officer, PO Box 41930, Rochester, New York 14604 or LTCPrivacy.Officer@MedAmericaLTC.com]. Revocation will not affect any action taken in reliance on this authorization before written notice of revocation is received.

Your Rights. Although voluntary, this authorization is required to determine your eligibility for enrollment. If you choose not to complete this authorization, we will be unable to determine your eligibility for insurance. By signing this authorization, you acknowledge that if you authorize a person or organization to receive your protected health information that is not a health plan, covered health care provider or health care clearinghouse subject to federal health information privacy laws, they may further disclose the protected health information and it may no longer be protected by federal health information privacy laws.

PRINT APPLICANT NAME: _____

APPLICANT DATE OF BIRTH: _____ / _____ / _____
MM *DD* *YYYY*

APPLICANT SOCIAL SECURITY NUMBER: _____ - _____ - _____

☞☞ **APPLICANT'S SIGNATURE:** _____ **DATE:** _____

VIII. SIGNATURES AND AUTHORIZATIONS: To be completed by ALL Applicants.

1. **FRAUD 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 may commit a fraudulent insurance act, which is a crime that may subject such person to criminal and/or civil penalties not to exceed $5,000, plus the stated value of the claim for each violation, can apply.

2. **PROTECTION AGAINST UNINTENDED LAPSE:** I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this insurance policy for nonpayment of premium. I understand that notice will not be given until **31 days after** a premium is due and unpaid. I understand, also, that I have the right not to appoint a lapse designee. Therefore, **I select *one* of the following options:**

   ☐ **I elect NOT to designate** any person to receive such notice.

   ☐ **I designate** the person listed below to be notified by MedAmerica Insurance Company if my premium is not paid:

   Name:_____ Phone Number:_____

   Address:_____
   Street City State Zip

3. **INFLATION PROTECTION OPTION:** I have reviewed the Outline of Coverage and the graph that compare the benefits and premiums of this Policy with and without inflation protection, and

   ☐ **I ACCEPT inflation protection.**
   ☐ **I REJECT inflation protection.**

4. **EMPLOYER / ASSOCIATION:**

   Name:_____ Phone Number:_____

   Address:_____
   Street City State Zip

5. **DECLARATION AND APPLICATION CONDITIONS:**

To the best of my knowledge and belief, I have answered all questions completely and truthfully. I understand this application is for consideration and the company will use the information contained herein to determine if my application is accepted. I understand that the coverage I am applying for is medically underwritten and that my coverage will begin only when I am notified of the effective date of coverage, or if selected, my alternate effective date. To receive benefits under the policy, I understand I must satisfy the elimination period and the benefit eligibility requirements as set forth in the policy.

I acknowledge receipt of the Outline of Coverage and, if over 65, a Medicare Buyer's Guide: "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

I understand the Producer or subsequent assignee, and any managing entities (which may include an affiliate of the Company), may receive compensation, monetary and/or non-monetary, as a result of my purchasing this insurance.

CAUTION: If your answers on this application are incorrect or untrue, or you fail to include all material medical information requested, MedAmerica Insurance Company may have the right to deny benefits or rescind your policy.

I understand that with this signature I am agreeing with all applicable conditions contained in this Section.

Dated at: City_____State_____Month _____ Day_____Year_____

☞☞ **APPLICANT SIGNATURE:** _____

VIII. PRODUCER STATEMENT

1. Has the Applicant purchased any other health insurance policy from you during the past five (5) years? ***If Yes, provide the following information:***

COMPANY	TYPE OF POLICY	POLICY NUMBER	IN FORCE:
_____	_____	_____	☐ YES ☐ NO
_____	_____	_____	☐ YES ☐ NO

2. By my signature on this form I certify that:

(a) I have reviewed the current health insurance coverage of the Applicant and find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.
(b) I have consulted with the Applicant and have accurately recorded information supplied to me by the Applicant at the time application was made.
(c) I am in compliance with the insurance requirements in the state this application was solicited in and signed by the applicant.
(d) I have delivered the Outline of Coverage, and if over 65, a Medicare Buyer's Guide: "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."

_____ _____
Soliciting Producer Name (*Please print)* Writing Number

_____
Supervising General Agency Name

Telephone Number (Best number to reach soliciting producer) : (_____) - _____

☞☞ **SOLICITING PRODUCER SIGNATURE:_____ DATE: _____**

3. Are you SPLITTING the Commission Payment? ☐ YES ☐ NO

If YES, List all producers receiving compensation, their Writing Number(s), and % splits. The first producer listed **MUST** be the soliciting producer and the producer of record. Case splits must total 100%. (*Only Licensed and Appointed Producers/Brokers may receive compensation.)*

Soliciting Producer Name: _____ **Please Print First and Last Name**	Writing#: _____	_____ %	
Co-Producer Name: _____ **Please Print First and Last Name**	Writing#: _____	_____ %	
Co-Producer Name: _____ **Please Print First and Last Name**	Writing#: _____	_____ %	
Co-Producer Name: _____ **Please Print First and Last Name**	Writing#: _____	_____ %	**TOTAL: 100 %**

[Amount of Conditional Premium Check [(attached)]: $_____]
[As per the Conditional Receipt, Modal Premium is Required*
***If EFT, 1 months premium is required]**

Special Requests, Remarks, and Instructions: