MediQ65®

Medicare Supplement Insurance

2017
Application for Coverage

QualChoice®
HEALTH INSURANCE

MediQ65®

2017 Application for Coverage

MediQ65® Medicare Supplement Insurance

Thank you for your interest in the QualChoice MediQ65® for your Medicare Supplement insurance coverage. You must be age 65 or older, a resident of the State of Arkansas, and have both Medicare Part A and Medicare Part B to apply for these plans.

Please read the information carefully so we can process your application quickly. For faster service apply online at *MediQ65.com*.

1. Complete this form yourself or with the help of a broker/agent authorized to sell QualChoice MediQ65® plans.
2. Complete all required sections and answer each required question to avoid delays in processing. If certain sections do not apply to you, mark 'NA' for 'not applicable'.
3. If filling out by hand:
   a. Use dark blue or black ink. No pencil, please.
   b. Do not use liquid paper, correction tape or 'white out' to fix mistakes. If you make a mistake, mark through the wrong information, initial it and then give the right information.
   c. Sign and date this application and any attachments.
4. Make a copy of your application and any attachments for your records.
5. Return this **entire** application and any attachments to QualChoice.
6. **DO NOT** send money with this application. You will be billed later by the payment method you choose in Section XI.

Note:

- This application is a legal document. It will become part of your contract if you are approved for coverage. It is important that you provide all requested information and that it is accurate and legible.
- Information in your application will be used and disclosed only as permitted by our *Privacy Policy* available at *MediQ65.com*.
- In answering the questions in this application:
  - ✗ Do not include any medical history or information about genetic testing, services or counseling.
  - ✗ Do not include any information about a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

Policy Effective Dates

The policy effective date will be the 1st of the month after your application is approved and processed.

Effective date of coverage cannot be:

- Prior to your Medicare Part A and Part B effective dates.
- Prior to your termination from a Medicare Advantage plan.
- Prior to your application submission date.

Service Area—Arkansas Counties: Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Clark, Columbia, Conway, Crawford, Dallas, Faulkner, Franklin, Garland, Grant, Hempstead, Hot Spring, Howard, Jefferson, Johnson, Lafayette, Little River, Logan, Lonoke, Madison, Marion, Miller, Montgomery, Nevada, Newton, Ouachita, Perry, Pike, Polk, Pope, Pulaski, Saline, Scott, Searcy, Sebastian, Sevier, Union, Van Buren, Washington, Yell

For questions or help, call a MediQ65® Sales Manager at 501.228.7111 or 855.633.4765 Mon.–Fri., 8 a.m.-5 p.m.

Section I. Who Is Applying?

First Name	MI	Last Name

Gender ☐ Male ☐ Female	Date of Birth (MM/DD/YYYY)	Social Security Number

Primary Phone Number	Secondary Phone Number	Best Time to Call ☐ AM ☐ PM

Residential Street Address	City	State	Zip Code

In what county do you live? *Must live in one of the Arkansas counties listed on page 1.*

Billing Address (if different from residential address)	City	State	Zip Code

Mailing Address (if different from residential address)	City	State	Zip Code

IMPORTANT DECISION:
By checking **YES** below**,** I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage to my email address below. This includes, but is not limited to, my *Medicare Supplement Policy*, all Explanation of Benefits describing how my claims have been paid, billing invoices, renewal notices, and any other communications.

I understand that I can cancel my decision to have these documents and communications sent to me electronically by calling QualChoice at 800.235.7111 or 501.228.7111. I also understand that I can ask QualChoice at any time to provide me with any of these documents in paper form by regular mail. I agree to contact QualChoice if my email address changes so these important communications will come to my new email address.

☐ Yes ☐ No **E -Mail Address** _____

Section II: Eligibility Information

If you lost, or are losing other health insurance coverage, and received a notice from your previous insurer saying you were eligible for Guarantee Issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed accepted in one or more of our Medicare supplement plans.

If this applies to you, please send a copy of the notice from your previous insurer with this application. Your application cannot be processed as a Guarantee Issue without it.

Please check (✓) Yes or No

1. Did you turn age 65 in the last 6 months? ☐ YES ☐ NO

a. Did you enroll in Medicare Part B in the last 6 months? ☐ YES ☐ NO

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

2. 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

a. If **YES**, will Medicaid pay your premiums for this Medicare supplement policy? ☐ YES ☐ NO

b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ YES ☐ NO

3. If you had coverage from any Medicare plan, other than Original Medicare, within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO, PPO or PFFS), please fill in your **Start Date** and **End Date** below.

Start Date (MM/DD/YYYY)_____ **End Date** (MM/DD/YYYY) _____

4. If you are still covered under the other Medicare plan. Do you intend to replace your current coverage with this new Medicare supplement policy? ☐ YES ☐ NO

a. Was this your first time in this type of Medicare plan? ☐ YES ☐ NO

b. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO

c. Did you move out of the service area of your Medicare Advantage plan? ☐ YES ☐ NO

d. Did your Medicare Advantage plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guaranteed issue into a Medicare Supplement plan? ☐ YES ☐ NO

5. Do you have another Medicare supplement policy in force? ☐ YES ☐ NO

a. If **YES**, what is the name of the company? _____ Name of Plan? _____

b. If **YES**, do you plan to replace your current Medicare supplement policy with this MediQ65 supplement policy? If **yes**, the ***Notice of Replacement Questionnaire*** must be included with your application (form available at *QualChoice.com*). ☐ YES ☐ NO

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

a. If **YES**, Name of Carrier: _____

Type of Policy: _____

b. If **YES**, what are the dates of coverage under the other policy?

Start Date (MM/DD/YYYY) _____ **End Date** (MM/DD/YYYY) _____

Section III. Your Medicare Insurance Information

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65®.

Please FILL IN THE BLANKS below to match your red, white and blue Medicare card.

Medicare Claim Number
Effective Dates (from your Medicare card)
Hospital Part A (MM/DD/YYYY)
Medical Part B (MM/DD/YYYY)

Section IV: Choose Your Plan. *Check (✓) only one.*

Enroll me in the following plan:	**Plan A** ☐	**Plan F** ☐	**High Deductible Plan F** ☐	**Plan G** ☐	**Plan K** ☐	**Plan N** ☐

Do you currently have QualChoice health coverage? ☐ YES ☐ NO

If **YES,** please print your QualChoice ID number: _____

Important Information

Please read carefully before continuing.

Medigap Open Enrollment Period

If you are applying during your Medigap Open Enrollment Period you do not need to answer the medical questions in Sections V-VIII. Please continue your application at Section IX.

If you are NOT applying during your Medigap Open Enrollment Period, or you do not have a guaranteed issue right**,** you must answer all the medical questions in Sections V-VIII. Acceptance of your application is based on your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage, Arkansas residency, and our review of your answers to the medical questions. Your application cannot be processed unless all questions are answered.

Section V. Primary Care Physician Information

Complete Name and Address of Physician	Date of Last Visit	Reason for Visit

Section VI. Medical Questions *Please complete if this section applies to you.*

1. What is your height? _____ft. _____in.
2. What is your weight? _____lbs.

3. Are you Medicare disabled? If **YES:** please describe disability condition(s) below. ☐ YES ☐ NO

_____

_____

_____

4. Have you ever been declined or rejected for the issuance of life, accident, health or long term care insurance? ☐ YES ☐ NO
   If **YES:** Name of Carrier _____Year_____
   Reason_____

_____

5. Have you used any form of tobacco in the past 12 months? ☐ YES ☐ NO
   If **YES:** type of tobacco _____Amount of Use _____

6. In the **last 5 years** have you:
   a. Had home health care services for any reason? If **YES:** please explain below. ☐ YES ☐ NO

_____

_____

_____

   b. Required the assistance of any other individual for performance of any activities of daily living? If **YES:** check all that apply below. ☐ YES ☐ NO

   ☐ Bathing ☐ Dressing ☐Transferring ☐ Eating ☐ Toileting ☐ Continence

   c. Used any addictive or non-addictive drug or substance except as provided by a physician? If **YES:** please explain below. ☐ YES ☐ NO

_____

_____

_____

   d. Used alcohol in amounts greater than 3 drinks per day? ☐ YES ☐ NO

7. Have you:
   a. Ever had inpatient or outpatient cardiac surgery or other cardiac procedures? ☐ YES ☐ NO
      If **YES:** when and what type? _____

_____

   b. Ever been diagnosed and/or treated for cancer (other than skin cancer)? ☐ YES ☐ NO
      If **YES:** when and what type? _____

_____

   c. Been hospitalized since turning age 65? If **YES:** ☐ YES ☐ NO
      When: _____ No. of Total Days: _____
      Reason for Stay: _____

_____

_____

Each condition below must have at least **one** box checked. If **none** of the conditions apply, you must check 'None of the above'. Give full details in **Section VII: Additional Medical Information** for each condition checked. Do not include any medical history or information linked to genetic testing, services or counseling. Also, do not include any information about a genetic disease that has not manifested itself or has been diagnosed principally on genetic information.

8. Have you ever been diagnosed or treated for

- ☐ Heart Bypass Surgery
- ☐ Hodgkin's Disease
- ☐ Internal Defibrillator
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Malignancy, Current
- ☐ Melanoma
- ☐ Non-Hodgkin's Lymphoma
- ☐ Pacemaker
- ☐ Stents
- ☐ None of the above

9. In the last ten (10) years have you been treated for (includes medication) or been told by your physician that you had:

- ☐ Breast Cancer
- ☐ Prostate Cancer
- ☐ Uterine Cancer
- ☐ None of the above

In the **last three (3) years** have you been treated for (includes medication), or been told by your physician, you had any of the following:

10. Brain or Nervous System Condition

- ☐ Alzheimer's disease or Senile Dementia
- ☐ Amyotrophic Lateral Sclerosis (ALS - Lou Gehrig's disease)
- ☐ Convulsion, Epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple Sclerosis, Muscular Dystrophy or Myasthenia Gravis
- ☐ Neuritis or Polyneuritis
- ☐ Paralysis or Cerebral Palsy
- ☐ Parkinson's disease
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ None of the above

11. Respiratory Condition

- ☐ Asthma
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Cystic Fibrosis
- ☐ Home oxygen therapy
- ☐ Lung Transplant
- ☐ Obstructive or Reactive Airway Disorder
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ None of the above

12. Digestive Condition

- ☐ Cirrhosis, Hepatitis
- ☐ Crohn's Disease or Ulcerative Colitis
- ☐ Diverticulitis
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric Esophageal Reflux Disorder (GERD)
- ☐ Gastric or Duodenal Ulcer
- ☐ Irritable Bowel Syndrome
- ☐ Pancreatitis
- ☐ Any other disorder or surgery of the stomach, intestines, liver, gallbladder or rectum
- ☐ None of the above

13. Ears/Eyes/Nose/Throat Condition

- ☐ Cataracts or Glaucoma
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ None of the above

14. Glandular Condition

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
  - Do you take insulin? ☐ Yes ☐ No
  - Amount of medications by mouth? ☐ 0-2 ☐ 3+
  - Blood sugar reading _____
  - Date of blood sugar reading _____
- ☐ Thyroid disorder
- ☐ Any other disorder of the pancreas, pituitary, adrenal or other glands
- ☐ None of the above

15. Circulatory Condition

- ☐ Angina
- ☐ Cerebrovascular accident (stroke) including Transient Ischemic Attack (TIA)
- ☐ Chest pain, shortness of breath
- ☐ Heart Attack, Myocardial Infarction, Arteriosclerosis, Coronary Artery Disease, Stent placement and/or Angioplasty
- ☐ Heart Murmur
  - Do you take medication for your heart murmur? ☐ Yes ☐ No
- ☐ Hemophilia, Factor 8 or 9 Disease
- ☐ High blood pressure
- ☐ Palpitation of the heart
  - Do you take medication for palpitation of the heart? ☐ Yes ☐ No
- ☐ Any other condition of the heart, blood, blood vessels or circulatory system
- ☐ None of the above

16. Cancer, Lymphatic System, Blood, Or Skin Condition

- ☐ Anemia
- ☐ Neoplasm or tumor
- ☐ Any other cancer
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ None of the above

17. Musculoskeletal Condition

- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fibromyalgia
- ☐ Fracture(s) or broken bone(s)
  - Was the bone exposed? ☐ YES ☐ NO
- ☐ Lupus, systemic
- ☐ Psoriatic arthritis
- ☐ Rheumatoid Arthritis
- ☐ Any other arthritis
- ☐ Any other disorder of the muscles, bones or joints
- ☐ None of the above

18. Kidney, Urinary, Reproductive Condition

- ☐ Abnormal Pap Smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, Renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ None of the above

19. Mental, Emotional Condition or Substance Abuse

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric/psychological treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ None of the above

20. Other Condition

- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder, or HIV
- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Surgery, procedure, or test advised by physician but not completed
- ☐ Transplant recipient
- ☐ Unexplained or unintentional weight loss of 10 pounds or more
- ☐ Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e., pins, wires, screws, shunts, stents)
- ☐ Any injury deformity, incapacitation, disease or condition not listed elsewhere
- ☐ None of the above

Section VII. Additional Medical Information

1. Give full details below to conditions checked in Section VI, Questions 8-20.
2. Include all treatments provided or planned that apply in the **Type of Treatment** section. Example treatments are:
   - Surgery Hospitalization
   - Emergency room visit
   - Chiropractic treatments
   - Nursing Home confinement
   - Doctor visits
   - Rehabilitation therapy (speech, physical, occupational)
3. Please make sure to include all treatments that apply.

Question No.	Condition/Illness / Type of Treatment	First diagnosis YR	Most recent visit MO	Most recent visit YR	Total # of Visits	Recovery	Complete Name and Address of Physician
15	**Condition/Illness:** Arthritis **Type of Treatment:** Doctor Visit	2016	01/16 MO/YR		2	☐None ☒Partial ☐Full	Jane Smith, MD 123 Any Street Any Place, AR
	Condition/Illness: Type of Treatment:		___/___			☐None ☐Partial ☐Full	
	Condition/Illness: Type of Treatment:		___/___			☐None ☐Partial ☐Full	
	Condition/Illness: Type of Treatment:		___/___			☐None ☐Partial ☐Full	

	Condition/Illness: Type of Treatment:		___/____		☐None ☐Partial ☐Full	
	Condition/Illness: Type of Treatment:		___/____		☐None ☐Partial ☐Full	

Section VIII. Prescription Questionnaire

1. Are you currently taking blood thinners? ☐ YES ☐ NO
2. Are you currently taking any prescription medication, or have you taken prescription medication in the **last three (3) years**? ☐ YES ☐ NO
3. If you answered **YES**, please provide full details below. A print-out from the pharmacy is **not** acceptable.

Name of Medication	Dosage	Specific Condition or Illness	Start Date (MO/YR)	Stop Date (MO/YR)	Degree of Recovery	Complete Name & Address of Physician
Tylenol	1000 mg	Osteoarthritis	06/15	Current	☐None ☒Partial ☐Full	Jane Smith, MD 123 Any Street Any Place, AR
					☐None ☐Partial ☐Full	
					☐None ☐Partial ☐Full	
					☐None ☐Partial ☐Full	
					☐None ☐Partial ☐Full	
					☐None ☐Partial ☐Full	
					☐None ☐Partial ☐Full	
					☐None ☐Partial ☐Full	

Section IX: Important Information for Applicant. Please read carefully.

Send no money with this application. You will be billed by the payment method you choose in Section XI.

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 multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 that 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.
5. 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 the suspension.
6. 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).
7. I understand that if I am not in my Medigap Open Enrollment Period, or do not have a Guarantee Issue right, that the policy I am applying for will not pay any benefits during the first six (6) months for: any disease or condition for which I received medical advice or for which treatment was recommended or performed by a doctor within six (6) months before this policy is issued. If I have prior creditable coverage through another Medicare Supplement policy that ends within 63 days of the date of this application, credit for the creditable coverage will be applied to the pre-existing period.

This application cannot be processed without your signature.

In signing below, I represent and acknowledge:

1. I should not cancel any coverage I currently have until I am notified of QualChoice's decision.

2. An agent/broker involved in this insurance transaction may receive compensation from QualChoice for services related to the placement of this insurance. Any such compensation is included in the insurance premium paid by the insured. For more information on the compensation involved in this transaction, please direct your inquiry to the broker/agent.

3. If my application is accepted relying on my representations on this document, any coverage which may be issued to me shall be invalid if based on false information.

4. I agree any provider of medical services or supplies is authorized and directed to furnish QualChoice all records or copies thereof, relating to such services or supplies.

5. I authorize and release to QualChoice, Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits.

6. QualChoice may call me for additional information that may help with the timely processing of my application.

7. The statements and answers given in this application and any signed and dated addenda to this application (both front and back) are true, complete and correctly recorded.

8. I have read and understand the **Important Information for Applicant** (Sect. IX).

9. I acknowledge and understand that consistent with the requirements of the Genetic Information Nondiscrimination Act of 2008, QualChoice does not use genetic information for underwriting purposes or any other purpose prohibited by applicable law. QualChoice has requested that in answering the questions in this application that I do not include any family medical history or information related to genetic testing, genetic services or genetic counseling. QualChoice has also requested that I do not include information regarding a genetic disease that has not manifested itself or has been diagnosed principally on genetic information. I further acknowledge that QualChoice has directed me to omit or remove from this application any genetic information.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

- I, the applicant, certify that I signed this application in the state of Arkansas.
- I, the applicant, or my authorized representative, acknowledge receipt of the following:

☐ ***Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare*** (at Medicare.gov) and ***Outline of Medicare Supplement Coverage*** from QualChoice.

Signature of Applicant	**Date Signed (MM/DD/YYYY)**
X	

FOR BROKER/AGENT ONLY

If application is being made through a broker/agent, the broker must complete the following.

Note: Before this application can be processed, the broker/agent's current health and life license must be on file with QualChoice. The broker/agent must also be appointed with QualChoice as a MediQ65® representative.

☐ I have read and understand the *MediQ65® Application for Coverage*.

I additionally certify that:

☐ The applicant has Medicare Part A and Part B.
☐ The policy applied for will not duplicate any health insurance coverage.
☐ I have requested and received documentation that the policy applied for will not duplicate any coverage.
☐ The applicant has received: ***Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare*** and the ***Outline of Medicare Supplement Coverage*** for the policy applied for.

Agency Federal Tax ID # (If Applicable)	**Broker/Agent License #**	**Print Name Broker/Agent**
Agency Name	**Phone No.**	**Email Address**

Signature Broker/Agent **x**	**Date Signed (MM/DD/YYYY)**

List below all health insurance policies you have issued to this applicant that are still in force and any other health insurance issued in the **past five (5) years** that are no longer in force and submit with this application as required.

NAME OF POLICY	NAME OF INSURANCE COMPANY	POLICY DATE (MM/DD/YYYY)	
		To	From

This application cannot be processed without your signature.

Section X: Authorization to Disclose Protected Health Information (PHI)

1. I authorize any medical professional, medical care institution, other provider of health care services or supplies, the Medical Information Bureau (MIB), reinsurer, health plan, prior insurance carrier, consumer reporting agency, other third party medical and/or pharmaceutical databases or other organization, institution or person, that has any records on me or my health to provide QualChoice, any third party retained by QualChoice, or its reinsurers, information with respect to any physical or mental condition, treatment or any non-medical information on me.
2. I understand that information obtained as a result of this authorization will be used for the purpose of underwriting and determining eligibility for coverage.
3. This information shall also be used by QualChoice in investigating and paying claims for benefits.
4. I understand that in the course of their business operations, QualChoice may disclose this information to others as required or permitted by law and as set out in the QualChoice *Privacy Notice*.
5. I understand that information provided under this authorization if re-disclosed will no longer be protected. However, QualChoice and its associates are protected by federal and state privacy laws and regulations.
6. I specifically authorize QualChoice to release necessary information obtained by QualChoice about me to my broker/agent.
7. This authorization permits release of information related to substance use or abuse, but does not provide for the disclosure of psychotherapy notes as defined in 45 CFR § 164.501.
8. I acknowledge that signing this authorization is a condition of my enrollment for health coverage by QualChoice.
9. I understand that I may terminate this authorization by sending a written revocation to QualChoice, Attn: MediQ65®, P.O. Box 25626, Little Rock, AR 72221-5626. However, if I revoke this authorization before I am enrolled in the MediQ65 policy, my application for coverage will be denied.
10. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims.
11. A copy of this authorization is as valid as the original.
12. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signature in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signature Act A.C.A §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i)
13. QualChoice may release any information it obtains about me to MIB or any member company for purposes described in QualChoice's *Privacy Notice*.

Print Name of Applicant	**Signature of Applicant** **X**	**Date Signed** (MM/DD/YYYY)

This application cannot be processed without your signature.

Section XI. Payment Authorization Form - *Select one of the four payment methods below.*

☐ **MONTHLY:** I authorize QualChoice to bill my MediQ65® premium on a monthly basis.

☐ **Paper bill** ($2.00 monthly fee applies.) Your monthly invoice will be mailed to your Billing Address listed in Section I.	☐ **Bank draft*** ☐ 24th of preceding month ☐ 5th of current month

☐ **QUARTERLY:** I authorize QualChoice to bill my MediQ65® premium on a quarterly basis. ***Note**: Rates may change during the year. You may receive a credit or have to pay the rate difference at the end of the quarter.*

☐ **Paper bill** Your quarterly invoice will be mailed to the Billing Address listed in Section I.	☐ **Bank draft*** ☐ 24th of preceding month ☐ 5th of current month

☐ **ANNUAL:** I authorize QualChoice to bill my MediQ65® premium on an annual basis. ***NOTE**: Rates may change during the year. You may receive a credit or have to pay the rate difference at year-end.*

☐ **Paper bill** Your annual invoice will be mailed to the Billing Address listed in Section I.	☐ **Bank draft*** ☐ 24th of preceding month ☐ 5th of current month

*Bank Draft -- I authorize QualChoice to draft the checking/savings account listed below for payment of my MediQ65® premium. This authorization is valid until I give written notice of cancellation to QualChoice. If I cancel my bank draft after agreeing to it, I will also be terminating my coverage, unless I send written notice to QualChoice of my desire to continue coverage at least 20 days before the bank draft withdrawal date. If my bank draft is rejected due to insufficient funds, QualChoice may charge me a $20 fee. If my bank draft is rejected, with or without cause, whether intentionally or inadvertently, QualChoice will have no liability even though such may result in the cancellation of my coverage. Your first month's premium will be drafted upon initial acceptance of coverage.

Name of Bank or Financial Institution	Account Type *(Check One)* ☐ Checking ☐ Savings
Bank Account Number	9 Digit Bank Routing No.

Account Holder Name	Billing Address	City	State	Zip

Account Holder Signature **X**	**Date Signed MM/DD/YYYY)**

Authorized Signature: *By signing below, I agree to all the terms and conditions stated in the payment method checked above. This payment method is valid until QualChoice gets written notice of my wish to change my payment method 20 days before my next premium due payment. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be cancelled at QualChoice's discretion.*

Print Name of Applicant	**Signature of Applicant** **X**	**Date Signed** (MM/DD/YYYY)

Social Sec. # or Member ID #	**Broker/Agency Name (if applicable)**

Changes in billing methods must mailed or faxed to:	For questions, call:
QualChoice Attn: Finance P.O. Box 25610 Little Rock AR 72221 Fax 501.707.6728	501.228.7111 or 800.235.7111, ext. 7023

For More Information

MediQ65® Medicare Supplement Insurance Plan
12615 Chenal Parkway, Ste. 300
Little Rock, AR 72211

P.O. Box 25626
Little Rock, AR 72221

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Toll Free 855.MEDIQ65 (855.633.4765)
www.MediQ65.com

Senior Health Insurance Information Program (SHIIP – State of Arkansas)
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