

Medicare Supplement Insurance Program

Sponsored by the American Medical Association

AMA INSURANCE

IT'S EASY TO ENROLL:

1. Please complete, date and sign this form, and check the Plan you want. Make sure you answer all the questions and read all the statements.
2. Send NO MONEY at this time. You will be billed when your Insurance Certificate is mailed.
3. Return this Enrollment Form (be sure to have your spouse sign if also enrolling) in the postage-paid envelope provided to:
AMA Insurance Agency, Inc.
330 North Wabash Avenue, Suite 39300
Chicago, IL 60611-5885.

Prefer to enroll by phone? Call **1-888-627-6692**, Monday through Friday, 8 a.m. to 5 p.m. CST.

Response Requested by:



This Medicare Supplement Enrollment Form for both Physician & Spouse

Administered by:

AMA Insurance Agency, Inc.
330 North Wabash Avenue, Suite 39300
Chicago, IL 60611-5885
A Subsidiary of the American Medical Association (AMA)

Underwritten by:

Transamerica Life Insurance Company
Cedar Rapids, Iowa

PLEASE COMPLETE

I wish to enroll

Phone No. (_____) _____

Name of Physician whose Spouse is enrolling for coverage.

Spouse's Name (if enrolling)

E-mail address

Please attach a copy of your Medicare ID card with this enrollment form to expedite electronic filing and speed the processing of your Part B claim.

Physician:

Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ (Month/Day/Year)

Sex: Male Female

Medicare ID Number (Found on your Medicare ID Card)

Desired future effective month (Month/Year): ____/____

Spouse: (If enrolling)

Social Security Number: _____ - _____ - _____

Date of Birth: ____/____/____ (Month/Day/Year)

Sex: Male Female

Medicare ID Number (Found on your Medicare ID Card)

Desired future effective month (Month/Year): ____/____

Please read and complete the other side ►

CHECK BOX FOR DESIRED COVERAGE:

Physician: Plan A Plan B Plan C¹ Plan D Plan F¹ Plan G Plan K Plan L Plan M Plan N

Spouse: Plan A Plan B Plan C¹ Plan D Plan F¹ Plan G Plan K Plan L Plan M Plan N

¹Please Note: Only applicants first eligible for Medicare before 2020 may purchase Plans C, F and high deductible F.

PLEASE BILL (Choose one):

Quarterly Semi-annual Annual EFT Monthly (Electronic Funds Transfer)

Please note: Effective date will be disclosed on the Certificate Schedule Page.

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

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. PLEASE ANSWER ALL QUESTIONS to the best of your knowledge. (Please mark yes or no below with an "X".)

	Physician	Spouse
1) Your Acceptance May be Guaranteed.		
a) Did you turn age 65 in the last 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Did you enroll in Medicare Part B in the last 6 months? If yes, what is the effective date?	<input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____ mo day year	<input type="checkbox"/> Yes <input type="checkbox"/> No ____/____/____ mo day year
c) Are you younger than age 65 and eligible for Medicare by reason of disability as defined by federal law?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Are you enrolled [or expected to be enrolled] in Medicare Part A and Part B?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) If yes, what is the effective date of Part A _____; Part B _____?		
2) Premium Assistance Questions. (Questions we are required to ask)		
a) Are you covered for medical assistance through the state Medicaid program? (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.) Will Medicaid pay your premiums for this Medicare Supplement policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Replacement Questions. (Answer only if you are replacing coverage)		
■ Medicare Advantage:		
a) If you had coverage from any Medicare plan other than the original Medicare within the past 63 days (for example, a Medicare Advantage Plan, or Medicare HMO, or PPO) fill in your start and end dates. If you are still covered under this plan leave "END" blank.	Start: _____ End: _____	Start: _____ End: _____
b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
■ Medicare Supplement:		
a) Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Did you drop a Medicare Supplement policy to enroll in this Medicare plan?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Do you have another Medicare Supplement policy in force?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) If so, with what company, and what plan do you have? Company: _____ Plan: _____		
e) If so, do you intend to replace your current Medicare Supplement policy with this policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE AND BELIEF

(Continued)	Physician	Spouse
<p>■ Other</p> <p>a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan)</p> <p>b) If so, with what company, and what kind of policy? Company: _____ Plan: _____</p> <p>c) What are your dates of coverage under the other policy? (If you are still covered by the other policy, leave “END” blank).</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Start: _____ End: _____</p>	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Start: _____ End: _____</p>

MEDICARE SUPPLEMENT INFORMATION TO CONSIDER

- You do not need more than one Medicare Supplement policy or certificate.
- If you purchase this Certificate you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy or certificate.
- If, after purchasing this certificate, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement certificate 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 certificate (or, if that is no longer available, a substantially equivalent policy or certificate) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement certificate provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your certificate was suspended, the reinstated certificate will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare Supplement certificate or 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 certificate or 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 certificate or 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 certificate or policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement certificate or policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

1-888-627-6692

For more information, call this toll-free number for prompt, courteous service. Experienced, knowledgeable service specialists will gladly assist you. Monday through Friday, 8:00 a.m. to 5:00 p.m., CST.

Please read the next page ►

IMPORTANT - PLEASE READ AND SIGN

I hereby enroll for Medicare Supplement coverage issued by Transamerica Life Insurance Company. **I understand that this coverage will not pay benefits for conditions for which I have received medical treatment or advice within the last 6 months prior to the effective date until I have been insured for 6 consecutive months.** If I had creditable health insurance coverage within 63 calendar days of enrolling in this plan, or if I am an Eligible Person enrolled within 63 days of termination, then this pre-existing conditions limitation will be waived to the extent that it was satisfied under the replaced coverage. This waiver will apply only to prior creditable coverage which includes, but is not limited to, coverage under a group health plan, health insurance coverage, Medicare Supplement, Medicare Parts A and B, Medicaid, TRICARE, a state health benefits risk pool or the Federal Employees Health Benefits Plan (FEHB).

PLEASE NOTE: If you are currently enrolled in a Medicare Risk HMO plan, you are responsible for terminating your HMO coverage once you apply for this plan. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.

I understand that my acceptance into this AMA-sponsored Plan is GUARANTEED with no medical information required and that the pre-existing conditions limitation is not applicable if 1.) I am enrolled in Medicare Parts A and B or, 2.) if I have been covered by the AMA-sponsored Catastrophic Major Medical or Hospital Income Plan for at least the 12 months prior to the date this Medicare Supplement takes effect.

If you are age 65 or older, enrolled in Medicare Parts A and B and your premium is paid when due, your coverage will be effective on the first day of the month after your enrollment form is received by AMA Insurance Agency, Inc. (or on the first day of the following month if received on the 11th of the month or later).

The undersigned applicant certifies that he/she has read, had read to him/her, the completed application and that the applicant realizes any false statement or misrepresentation in the application may result in a loss of coverage under the policy.

Any person who with intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated the state law.

I acknowledge that I have read all statements:

Physician's Signature X _____ Date _____

Spouse's Signature X _____ Date _____

Your 30-Day Right to Return Your Certificate Takes the Risk Out of Enrolling Now

Enroll today. When your Certificate arrives, examine it carefully. Take up to 30 days, if you like, to discuss it with your family, friends, lawyer, accountant or advisor. If, for any reason, you decide during the 30 days that you do not need this supplemental protection, write "cancel" across the face of your Certificate and mail back to AMA Insurance Agency, Inc. Any premium paid will be refunded in full and your Certificate will be considered never issued.

Underwritten by Transamerica Life Insurance Company under Group Policy No. MS9000GPT

Please read and complete the Authorization Agreement if Monthly EFT (Electronic Funds Transfer) is desired.