

**State:** Arkansas **Filing Company:** QualChoice Life and Health Insurance Company, Inc.  
**TOI/Sub-TOI:** MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan  
**Product Name:** MediQ65  
**Project Name/Number:** /

### Filing at a Glance

Company: QualChoice Life and Health Insurance Company, Inc.  
 Product Name: MediQ65  
 State: Arkansas  
 TOI: MS05I Individual Medicare Supplement - Standard Plans  
 Sub-TOI: MS05I.015 Multi-Plan  
 Filing Type: Form  
 Date Submitted: 10/24/2012  
 SERFF Tr Num: QUAC-128741169  
 SERFF Status: Closed-Approved-Closed  
 State Tr Num:  
 State Status: Approved-Closed  
 Co Tr Num:  
 Implementation: On Approval  
 Date Requested:  
 Author(s): Jim Couch, Liz Hubbard  
 Reviewer(s): Stephanie Fowler (primary)  
 Disposition Date: 11/05/2012  
 Disposition Status: Approved-Closed  
 Implementation Date:

State Filing Description:

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**General Information**

Project Name: Status of Filing in Domicile:  
 Project Number: Date Approved in Domicile:  
 Requested Filing Mode: Review & Approval Domicile Status Comments:  
 Explanation for Combination/Other: Market Type: Individual  
 Submission Type: New Submission Individual Market Type:  
 Overall Rate Impact: Filing Status Changed: 11/05/2012  
 State Status Changed: 11/05/2012  
 Deemer Date: Created By: Liz Hubbard  
 Submitted By: Liz Hubbard Corresponding Filing Tracking Number:  
 Filing Description:  
 online interactive application

**Company and Contact**

**Filing Contact Information**

Jim Couch, VP of Compliance jim.couch@qualchoice.com  
 12615 Chenal Parkway, Suite 300 501-228-7111 [Phone] 5118 [Ext]  
 Little Rock, AR 72211 501-707-6729 [FAX]

**Filing Company Information**

QualChoice Life and Health Insurance Company, Inc. CoCode: 70998 State of Domicile: Arkansas  
 12615 Chenal Parkway, Suite 300 Group Code: Company Type: Life & Health  
 Little Rock, AR 72211 Group Name: State ID Number:  
 (501) 228-7111 ext. [Phone] FEIN Number: 71-0386640

**Filing Fees**

Fee Required? No  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

Company	Amount	Date Processed	Transaction #
QualChoice Life and Health Insurance Company, Inc.	\$50.00	10/24/2012	64212623

**SERFF Tracking #:**

QUAC-128741169

**State Tracking #:****Company Tracking #:****State:** Arkansas**Filing Company:**

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	11/05/2012	11/05/2012

### Objection Letters and Response Letters

#### Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Stephanie Fowler	10/30/2012	10/30/2012

#### Response Letters

Responded By	Created On	Date Submitted
Liz Hubbard	11/05/2012	11/05/2012

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
MediQ65 Online Interactive Application	Note To Reviewer	Liz Hubbard	10/24/2012	10/24/2012

**SERFF Tracking #:**

QUAC-128741169

**State Tracking #:****Company Tracking #:****State:** Arkansas**Filing Company:**

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## Disposition

Disposition Date: 11/05/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Online Interactive Application	Approved-Closed	Yes

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## Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/30/2012
Submitted Date	10/30/2012
Respond By Date	11/30/2012

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Dear Jim Couch,

**Introduction:**

*This will acknowledge receipt of the captioned filing.*

**Objection 1**

*- Online Interactive Application, (Form)*

*Comments: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered."*

*If these questions are not going to be visible for applicants that are in their open enrollment or in a guaranteed issue situation, please specify this intent.*

**Conclusion:**

*A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.*

*Please feel free to contact me if you have questions.*

*Sincerely,*

*Stephanie Fowler*

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## Response Letter

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Response Letter Status	Submitted to State
Response Letter Date	11/05/2012
Submitted Date	11/05/2012

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Dear Stephanie Fowler,

**Introduction:**

Below is the response to your question about the medical questions in the MediQ65 online interactive application.

**Response 1**

**Comments:**

The medical questions section will not be shown to users if they are applying during their open enrollment period or indicate that they are guaranteed issue. They will just see a message that says "Step 3 - Medical Information is not required. You are applying during Open Enrollment and do not need to complete Step 3."

**Related Objection 1**

Applies To:

- Online Interactive Application, (Form)

Comments: R&R 27, Sec. 11.D. requires a statement above health questions on the application that "Under Open Enrollment, health questions are not required to be answered."

If these questions are not going to be visible for applicants that are in their open enrollment or in a guaranteed issue situation, please specify this intent.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

**Conclusion:**

Let me know if you need anything else.

Sincerely,

Liz Hubbard

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## Note To Reviewer

**Created By:**

Liz Hubbard on 10/24/2012 09:06 AM

**Last Edited By:**

Stephanie Fowler

**Submitted On:**

11/05/2012 02:47 PM

**Subject:**

MediQ65 Online Interactive Application

**Comments:**

As previously discussed, you have looked at this online interactive application and said that it is acceptable to file it for approval.

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## Form Schedule

### Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 11/05/2012	Online Interactive Application		AEF	Initial			MediQ65 Online Application_081412 PREVIEW to AID.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages

MediQ65 MediQ65 Medicare Supplement Insurance  
 12 pt font to be used throughout online application

**QualChoice** → **MEMBERS**

FOR: **MEMBERS** **BROKERS** **PROVIDERS** **EMPLOYERS** **ABOUT US**

Home / Members / MediQ65 Medigap Plans

**MediQ65**

**MEDICARE SUPPLEMENT PLANS**

**WHAT ARE MEDICARE SUPPLEMENT PLANS?**  
 Once you have Medicare **Parts A** and **B** in place and you review the coverage they provide, it's time to start thinking about your health care needs – both short and long term.

**MEDIQ65<sup>®</sup> MEDICARE SUPPLEMENT INSURANCE**  
 Cover what Medicare doesn't cover with a MediQ65<sup>™</sup> Medicare Supplement plan from QualChoice! QualChoice offers **Plans A, F, G, and N.**

**PLAN HIGHLIGHTS AND PREMIUM INFORMATION**  
 Click [here](#) for complete plan highlights, including premium information.

**WANT TO LEARN MORE or READY TO ENROLL?**  
 Download our MediQ65<sup>™</sup> documents below

**Download Application Medicare Supplement Insurance**

**Apply Online**

**MEDICARE RESOURCES**  
[Centers for Medicare & Medicaid Services \(CMS\)](#)  
[Choosing a Medigap Policy](#)  
[Social Security Administration](#)  
[Medicare - US Government Site](#)  
[SHIIP - Arkansas](#)

**CUSTOMER SERVICE**  
 For Information & Assistance  
**1.855.MEDIQ65**  
**(855.633.4765)**  
 Mon - Fri 8:00am-5:00pm CT  
 Email [mediq65@qualchoice.com](mailto:mediq65@qualchoice.com)

**MediQ65<sup>™</sup>**

MediQ65 Medicare Supplement plans are underwritten by QualChoice Life and Health Insurance Company, Inc. MediQ65 Medicare Supplement Plans are not connected with or endorsed by the U.S. government or the federal Medicare program.

0311MK004

Overview and Outline of Coverage docs will be updated with current LTF.  
 Paper application will be updated with current version.

NEXT PAGE

## MediQ65® Medicare Supplement Insurance

Apply for MediQ65® Medicare Supplement Insurance from QualChoice using our online application or download the printable version ([link to PDF](#)).

### Who can apply?

You must meet all three (3) requirements to apply.

1. Age 65+ or 6 months away from turning age 65
2. Arkansas Resident
3. Have both Medicare Part A and Medicare Part B

### Policy Effective Dates

The policy effective date will be the 1<sup>st</sup> 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

### Have a question?

Contact a MediQ65 Sales Representative

501.228.7111 or 855.633.4765 (855.MEDIQ65)

Monday-Friday

8 a.m. to 5 p.m.

### For more information about Medicare and Medigap

- Senior Health Insurance Information Program (SHIIP) [[hyperlink](#)]  
State of Arkansas  
SHIIP provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.  
1.800.224.6330 or 501.371.2782
- Medicare – 24 hours a day, 7 days a week  
1.800.633.4227 (1.800.MEDICARE)  
TTY/TDD users call 1.877.486.2048
- Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare [[hyperlink](#)]

### I am filling this out for:

- Myself.  
 My client. I am an agent/broker.

Pop up window if agent/broker:

Agent/Broker Name  
Agent/Broker email address  
Agent/Broker License #  
Agency Federal Tax ID #  
Phone Number

### NOTE:

1. This application is a legal document, which will become part of your contract if you are approved for coverage. It is very important that you provide all requested information and that it is accurate.
2. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at [www.mediq65.com](http://www.mediq65.com) [[hyperlink](#)]
3. Depending on your medical history, the online process could take from 15 to 45 minutes. You will not be able to save your information and come back, so make sure you have enough time to complete the entire application. **If there is no activity after 30 minutes, your session will end and the information you entered may be lost.**

Continue (> app continues)  Exit Application (> exits app)

NEXT PAGE

## Step 1 – Who is Applying?

Please enter the following information.

First Name

MI

Last Name

Gender

Date of Birth

Social Security Number

Primary Phone Number

Secondary Phone Number (Optional)

Best time to call (am or pm) (Optional)

Email Address (Optional) [if applicant selects 'Yes' under "Go Paperless" this field will pop up requiring applicant to complete]

Mailing Address

City

State[default to AR]

Zip

Is the Billing Address the same as the Mailing Address?  Yes  No

If no,

Billing Address

City

State [default to AR]

Zip

Is the Residential Address the same as the Mailing Address?  Yes  No

If no,

Residential Address

City

AR

Zip

Do you currently have QualChoice health coverage?  Yes  No [if yes] QualChoice ID Number

**Go Paperless!** [info will scroll in box]

Opt-in to receive important documents and communications via email

I want to do my part for the environment and reduce waste. By checking YES below, I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage electronically to my email address. This includes, but is not limited to, my Insurance Certificate of Coverage, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765). 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 that these important documents, notices and communications will come to my new email address.

Yes! I want to go paperless!

No. I want to receive my documents and communications through the mail.

NEXT PAGE

Step 2 – Eligibility

Please answer the following questions about your eligibility for a MediQ65® Medicare Supplement Plan

Application will auto-calculate whether they turned 65 in the last 6 months based on the date of birth field. If NO, this question will not show

Did you enroll in Medicare Part B in the last 6 months?  Yes  No

[if yes]

- What is the effective date?

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

**Note:** If you are participating in a Spend-Down Program and have not met your Share of Cost, please respond NO to this question.

[if yes]

- Will Medicaid pay your premiums for this Medicare supplement policy?

Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?  Yes  No

Have 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)  Yes  No

[if yes]

- Are you still covered under this plan? Y/N
- Start Date
- [if NO to 'Are you still covered under this plan?'] End Date
- Do you intend to replace your current coverage with this new Medicare supplement policy? Y/N
- Was this your first time in this type of Medicare plan? Y/N
- Did you drop a Medicare supplement policy to enroll in the Medicare plan? Y/N
- Did you move out of the service area of your Medicare Advantage plan? Y/N [If Yes, display a message below the question "Did you receive 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? [yes/no answer]" ]
- 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 guarantee issue into a Medigap policy? Y/N [If Yes, message will display below the question "Did you receive 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? [yes/no answer]" ]

Do you have another Medicare supplement policy in force?  Yes  No

[if yes]

- Name of the company
- Name of the plan
- Do you plan to replace your current Medicare supplement policy with this MediQ65 policy? Y/N

[if yes]

Contact a MediQ65 Sales Representative to request the *Notice of Replacement Questionnaire*.

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?)  Yes  No

[if yes]

- Name of the carrier
- Are you still covered under this policy?
- Start Date
- [if NO to "Are you still covered under this policy?"] End Date

[Show the following copy and 3 inputs **only** if person is 65 or older]

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65. Please provide the following information shown on your red, white and blue Medicare Health Insurance card.

Medicare Number (show image of actual Medicare Card)

			—			—					—	
--	--	--	---	--	--	---	--	--	--	--	---	--

Hospital (Part A) Effective Date (date field)

Hospital (Part B) Effective Date (date field)

**NEXT PAGE**

### Step 3A – Medical Information

Please answer the following health related questions. Acceptance of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage, Arkansas residency and our review of your answers to the medical questions.

Height

Ft	Inches

Weight

Lbs

Medicare Disabled?  Yes  No

[if yes]

- Please explain

#### Primary Care Physician

Please fill out the following information for your Primary Care Physician.

Name

Address

City

State

Zip

Date of last visit

Reason for visit

[Add another Primary Care Physician-> creates another set of inputs]

**NEXT PAGE**

### Step 3B – Medical History

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

Have you used any form of tobacco within the past 12 months?  Yes  No

[if yes]

- Type of tobacco
- Amount of use

**In the last five (5) years, have you:**

■ Had home health care services for any reason?  Yes  No

[if yes]

- Please explain

■ Required the assistance of any other individual for performances of any activities of daily living?  Yes  No

[if yes] Please check all that apply

- Bathing
- Dressing
- Transferring
- Eating
- Toileting
- Continence

■ Used any addictive or non-addictive drug or substance except as provided by a physician?  Yes  No

[if yes]

- Please explain

■ Used alcohol in amounts greater than 3 drinks per day?  Yes  No

Have you ever had inpatient or outpatient cardiac surgery or other cardiac procedures?  Yes  No

Have you ever been diagnosed and/or treated for cancer (other than skin cancer)?  Yes  No

Have you been hospitalized since turning age 65?  Yes  No

[if yes]

- How many total days were you in the hospital?

**NEXT PAGE**

**Step 3C – Medical Conditions**

For each section below, select all medical conditions that apply or select “None of the above”.

**In the past three (3) years have you been treated for, or been told you had, any of the following conditions?**

*When user selects “None of the Above” in any section, the section collapses to only show the checked “None of the Above” answer. A link will show up next to the section title that says “Show all” to make all options appear again. If “None of the Above” is then unchecked, the list will expand to show all options again.*

**BRAIN OR NERVOUS SYSTEM DISORDERS**

- 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 palsy
- Parkinson’s disease
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system

None of the above

**RESPIRATORY**

- Chronic obstructive pulmonary disease or asthma
- Obstructive or reactive airway disorder
- Home oxygen therapy
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above

**DIGESTIVE**

- Cirrhosis, hepatitis
- Crohn’s disease or ulcerative colitis
- Diverticulitis
- Gastric bypass surgery or other weight loss procedure
- Gastric or duodenal ulcer
- Irritable bowel syndrome
- Gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Any other disorder of the stomach, intestines, liver, gallbladder or rectum

None of the above

**EARS/EYES/NOSE/THROAT**

- Cataracts or glaucoma
- Any other disorder of the eyes, ears, nose, throat or esophagus

None of the above

**GLANDULAR**

- Adrenal disorders
- Diabetes, abnormal glucose
- Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands

None of the above

**CIRCULATORY**

- Angina, heart attack, myocardial infarction, arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- Cerebrovascular accident (stroke) including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur palpitation of the heart, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart surgery
- High blood pressure
- Hemophilia
- Any other condition of the heart, blood, blood vessels or circulatory system

None of the above

**CANCER, LYMPHATIC SYSTEM, BLOOD, OR SKIN DISORDERS**

- Anemia
- Cancer
- Hodgkin’s disease

- Leukemia
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any other disorder of the skin

None of the above

#### **MUSCULOSKELETAL**

- Arthritis
- Chronic fatigue
- Connective tissue disorder
- Fracture(s) or broken bone(s) — Exposed bone?  YES  NO
- Fibromyalgia
- Lupus, systemic
- Any other disorder of the muscles, bones or joints

None of the above

#### **KIDNEY, URINARY, REPRODUCTIVE**

- 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

#### **MENTAL/EMOTIONAL OR SUBSTANCE ABUSE**

- Anxiety, depression, emotional problems or nervous disorder
- Drug overdose
- Eating disorder
- Psychiatric treatment
- Any other mental, emotional disorder or situation

None of the above

#### **OTHER**

- Current patient in a hospital or nursing home
- Sarcoidosis
- Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.. pins, wires, screws, shunts, stents)
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder, or HIV
- Transplant recipient
- Surgery, procedure, or test advised by physician but not completed
- Unexplained or unintentional weight loss of 10 pounds or more
- Any injury deformity, incapacitation, disease or condition not listed elsewhere

None of the above

NEXT PAGE

### Step 3D Additional Medical Information

Please provide more information about the medical conditions you selected in the previous step.

If user selected a medical condition in Step 3C, then the following set of questions will be asked for each medical condition selected.

Condition/Illness [condition/illness field pre-populated with responses from Step 3C]

Type of treatment

[dropdown: Doctor visit, Emergency room visit, Surgery Hospitalization, Chiropractic treatments, Nursing Home confinement, Rehabilitation therapy, other]

[if other]

[show textbox]

Date of first diagnosis (month/year)

Date of most recent visit (month/year)

Total # of visits

Degree of recovery

[dropdown: None, Partial, Full]

Name of Physician

Address of Physician

Zip of Physician

Name at the time of visit (e.g. a maiden name)

If the applicant whose name is listed on this application is not the name given at the time of the physician visit(s), please indicate the name given at that time.

NEXT PAGE

### Step 3E – Prescription Information

Are you currently taking any prescription medication, or have you taken prescription medication in the last three (3) years?

Yes  No

[if yes]

- Name of medication
- Dosage
- Specific condition or illness [dropdown: populated with conditions from Step 3C, and other][If other][textbox]
- Start Date
- Are you currently taking this drug?  Yes  No
  - [if no] End Date
- Degree of recovery? [dropdown: None, Partial, Full]
- Name of Physician
- Address of Physician
- Zip of Physician

Add another Prescription Drug -> creates another set of inputs

NEXT PAGE

## Step 4 – Pick Your Plan

[If user is applying during Open Enrollment period, the following message will display “Step 3 – Medical Information is not required. You are applying during Open Enrollment and do not need to complete Step 3.”]

Review our four (4) plan options and pick the plan that is right for you!

### **Plan A** [[hyperlink to PDF](#)]

[Premium based on County]

This plan provides an economical basic benefit package, including coverage benefits for hospital and physician coinsurance, extended hospital stays and more. **Plan A** benefits are core benefits or basic benefits because all other Medigap plans include these basic or core benefits within their design.

### **Plan F** [[hyperlink to PDF](#)]

[Premium based on County]

This very popular plan includes basic benefits, skilled nursing coinsurance, full payment for Part A and Part B deductibles, and a foreign travel benefit.

Then, Part B excess charges are covered at 100% to round out this as a very comprehensive benefit package.

### **Plan G** [[hyperlink to PDF](#)]

[Premium based on County]

Plan G combines full coverage of the Part A deductible with payment for Part B excess charges at 100% (member pays Part B deductible).

Plan G also includes the core benefits, skilled nursing coinsurance, and a foreign travel benefit.

### **Plan N** [[hyperlink to PDF](#)]

[Premium based on County]

This Medigap plan covers 100% of the Medicare Part A deductible. It also covers 100% of the Medicare Part B coinsurance, except up to \$20 of the copayment for office visits and up to \$50 for emergency room visits.

## Step 5 – Payment Options

**Bank Draft (monthly)** [if selected] Show authorization statement

1. I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65® premium from the account indicated below.
2. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement.
3. I understand that by revoking the Monthly Bank Draft after I have agreed to it, I will also be terminating my MediQ65® coverage, **UNLESS** QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date.
4. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to \$20.00.
5. I understand that my first month's premium will be drafted upon initial acceptance of coverage.
6. I understand that for all other premiums I may select one of two bank draft dates.

"I understand and agree"

- Select from 2 options
  - 24<sup>th</sup> of the month preceding coverage month
  - 5<sup>th</sup> of the coverage month]
- Name of Bank
- Account type:  checking  savings]
- Bank Account Number
- 9 digit bank routing number
- Account Holder Name
- Account Holder Address
- Account Holder City
- Account Holder State
- Account holder Zip

**Monthly Billing**

A \$2.00 monthly service fee applies. Your monthly invoice will be mailed to your **billing address**.

**Quarterly Billing**

- I authorize QualChoice to bill my MediQ65® premium on a quarterly basis.
- This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement.
- I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due.

**[Back -> previous screen](#)**

**[Review Application -> continue to Review/Submit](#)**

## NEXT PAGE

### Review and Submit [fields 1-8 will auto-populate from information provided in application]

1. Name of person applying
2. Phone number
3. Email address (if Go Paperless was selected)
4. Mailing address
5. Plan selected
6. Plan premium
7. Payment selected
8. Billing address

### CAREFULLY READ and REVIEW THE FOLLOWING INFORMATION.

#### Payment Authorization [info in scroll box]

I agree to all terms and conditions expressed in the payment method I have chosen. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be terminated at QualChoice's discretion.

#### Authorization to Disclose Protected Health Information (PHI) [info in scroll box]

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 adjudicating 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 Notice of Privacy Practices.
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 photocopy 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 obtained by it about me to MIB or any member

**Important Information for Applicant [info in scroll box]**

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, 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.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- 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 reinstated 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 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).

**I represent and acknowledge the following:**

1. I have read and understand the **Important Information for Applicant**.
2. I should not cancel any coverage I currently have until I am notified of QualChoice’s decision.
3. 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 contact your agent/broker.
4. 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.
5. 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.
6. 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.
7. QualChoice, or a designated representative, may phone me for additional information that may help with the timely processing of my application.
8. That the statements and answers given in this application are true, complete and correctly recorded.

I, the applicant, certify that I signed this application in the state of Arkansas.

I, the applicant, or my authorized representative, acknowledges receipt of the following materials: *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare* (hyperlink) and *Outline of Medicare Supplement Coverage* (hyperlink) from QualChoice.

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, understand and agree to the terms listed above.

Full Name

[If agent/broker]

- I have read and understand the **MediQ65® Application for Coverage**.
- I certify that the applicant has received the *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 and that the applicant has Medicare Parts A and B.
- I certify that the policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the policy applied for will not duplicate any coverage.
- Before this application can be processed:
  - the agent/broker's current health and life license must be on file with QualChoice
  - the agent/broker must be appointed with QualChoice.

I, the agent/broker, understand and agree to the terms listed above.

**Full Name**

AGENT/BROKER REQUIRED TO INPUT FULL NAME (First, Last, MI)

List 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 Start Date

Policy End Date

Add another policy -> creates another set of inputs

[Back -> previous screen](#)

[Submit Application-> Submit application and go to confirmation page](#)

NEXT PAGE

## Application Received

Thank you for submitting your MediQ65 Medicare Supplement application!

One more thing! Please send a copy of the notice from your prior insurer concerning guaranteed issue or your right to buy a Medicare supplement insurance policy to the following address. We cannot process your application until this letter is received.

QualChoice MediQ65

PO Box 25626

Little Rock AR 72221-5626

You will be contacted within the next couple of weeks with the status of your application.

Have a question?

Contact a MediQ65 Sales Representative

501.228.7111 or 855.633.4765 (855.MEDIQ65)

Monday – Friday

8 a.m. to 5 p.m.

Download Plan Benefit Information [PDF for plan that they selected]

Download Copy of your MediQ65 Application [PDF]

If applicant previously stated they have a note from a prior insurer saying they were eligible for guaranteed issue, this sentence will display.

**\*Footer on all pages**

**Disclaimer**

MediQ65 Medicare Supplement plans are not connected with or endorsed by the U.S. Government or the Federal Medicare program.

**Fair Credit Reporting Act**

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65  
Underwriting Division  
PO Box 25626  
Little Rock, AR 72221-5626

MediQ65 Medicare Supplement plans are underwritten by QualChoice Life and Health Insurance Company, Inc. MediQ65 Medicare Supplement Plans are not connected with or endorsed by the U.S. government or the federal Medicare program.

SERFF Tracking #:

QUAC-128741169

State Tracking #:

Company Tracking #:

State: Arkansas

Filing Company:

QualChoice Life and Health Insurance Company, Inc.

TOI/Sub-TOI: MS05I Individual Medicare Supplement - Standard Plans/MS05I.015 Multi-Plan

Product Name: MediQ65

Project Name/Number: /

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	11/05/2012
Comments:			
Attachment(s):			
MediQ65 Online Interactive Application Flesch Letter Oct 2012.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	11/05/2012
Comments:			
Attachment(s):			
MediQ65 Online Application_081412 PREVIEW to AID.pdf			



October 24, 2012

Ms. Stephanie Fowler  
Arkansas Department of Insurance  
Life and Health Division  
1200 West Third Street  
Little Rock, AR 72201-1904

RE: MediQ65 Online Interactive Application

Dear Ms. Fowler:

This certifies that the documents being filed in conjunction with this letter do not meet the minimum score of forty (40) on the Flesch reading ease test as specified in Ark. Stat. Ann. § 23-80-206.

Although the score is lower than the minimum required, it should be approved in accordance with Ark. Stat. Ann. 23-80-207 and warranted due to the nature of the policy form and necessary inclusion of medical terminology and language drafted to conform to state and federal law.

Please feel free to contact me at any time should you need additional information or have any questions or comments.

Sincerely,

Liz Hubbard  
Associate Corporate Counsel  
liz.hubbard@qualchoice.com  
(501) 219-5129

MediQ65 MediQ65 Medicare Supplement Insurance  
 12 pt font to be used throughout online application

Overview and Outline of Coverage docs will be updated with current LTF.  
 Paper application will be updated with current version.

NEXT PAGE

## MediQ65® Medicare Supplement Insurance

Apply for MediQ65® Medicare Supplement Insurance from QualChoice using our online application or download the printable version ([link to PDF](#)).

### Who can apply?

You must meet all three (3) requirements to apply.

1. Age 65+ or 6 months away from turning age 65
2. Arkansas Resident
3. Have both Medicare Part A and Medicare Part B

### Policy Effective Dates

The policy effective date will be the 1<sup>st</sup> 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

### Have a question?

Contact a MediQ65 Sales Representative

501.228.7111 or 855.633.4765 (855.MEDIQ65)

Monday-Friday

8 a.m. to 5 p.m.

### For more information about Medicare and Medigap

- Senior Health Insurance Information Program (SHIIP) [[hyperlink](#)]  
State of Arkansas  
SHIIP provides free one-on-one counseling, education, and information to individuals with Medicare of all ages.  
1.800.224.6330 or 501.371.2782
- Medicare – 24 hours a day, 7 days a week  
1.800.633.4227 (1.800.MEDICARE)  
TTY/TDD users call 1.877.486.2048
- Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare [[hyperlink](#)]

### I am filling this out for:

- Myself.  
 My client. I am an agent/broker.

Pop up window if agent/broker:

Agent/Broker Name  
Agent/Broker email address  
Agent/Broker License #  
Agency Federal Tax ID #  
Phone Number

### NOTE:

1. This application is a legal document, which will become part of your contract if you are approved for coverage. It is very important that you provide all requested information and that it is accurate.
2. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be viewed at [www.mediq65.com](http://www.mediq65.com) [[hyperlink](#)]
3. Depending on your medical history, the online process could take from 15 to 45 minutes. You will not be able to save your information and come back, so make sure you have enough time to complete the entire application. **If there is no activity after 30 minutes, your session will end and the information you entered may be lost.**

Continue (> app continues)  Exit Application (> exits app)

NEXT PAGE

## Step 1 – Who is Applying?

Please enter the following information.

First Name

MI

Last Name

Gender

Date of Birth

Social Security Number

Primary Phone Number

Secondary Phone Number (Optional)

Best time to call (am or pm) (Optional)

Email Address (Optional) [if applicant selects 'Yes' under "Go Paperless" this field will pop up requiring applicant to complete]

Mailing Address

City

State[default to AR]

Zip

Is the Billing Address the same as the Mailing Address?  Yes  No

If no,

Billing Address

City

State [default to AR]

Zip

Is the Residential Address the same as the Mailing Address?  Yes  No

If no,

Residential Address

City

AR

Zip

Do you currently have QualChoice health coverage?  Yes  No [if yes] QualChoice ID Number

**Go Paperless!** [info will scroll in box]

Opt-in to receive important documents and communications via email

I want to do my part for the environment and reduce waste. By checking YES below, I agree that QualChoice can deliver all documents, notices and any other communications with respect to my MediQ65® coverage electronically to my email address. This includes, but is not limited to, my Insurance Certificate of Coverage, all explanation of benefits describing how my claims have been adjudicated, billing invoices, renewal notices, and any other communications. I understand I can change my mind at any time and revoke my decision to have these documents and communications sent to me electronically simply by contacting QualChoice at 1.855.MEDIQ65 (1.855.633.4765). 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 that these important documents, notices and communications will come to my new email address.

Yes! I want to go paperless!

No. I want to receive my documents and communications through the mail.

NEXT PAGE

Step 2 – Eligibility

Please answer the following questions about your eligibility for a MediQ65® Medicare Supplement Plan

Application will auto-calculate whether they turned 65 in the last 6 months based on the date of birth field. If NO, this question will not show

Did you enroll in Medicare Part B in the last 6 months?  Yes  No

[if yes]

- What is the effective date?

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

Note: If you are participating in a Spend-Down Program and have not met your Share of Cost, please respond NO to this question.

[if yes]

- Will Medicaid pay your premiums for this Medicare supplement policy?

Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?  Yes  No

Have 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)  Yes  No

[if yes]

- Are you still covered under this plan? Y/N
- Start Date
- [if NO to 'Are you still covered under this plan?'] End Date
- Do you intend to replace your current coverage with this new Medicare supplement policy? Y/N
- Was this your first time in this type of Medicare plan? Y/N
- Did you drop a Medicare supplement policy to enroll in the Medicare plan? Y/N
- Did you move out of the service area of your Medicare Advantage plan? Y/N [If Yes, display a message below the question "Did you receive 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? [yes/no answer]" ]
- 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 guarantee issue into a Medigap policy? Y/N [If Yes, message will display below the question "Did you receive 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? [yes/no answer]" ]

Do you have another Medicare supplement policy in force?  Yes  No

[if yes]

- Name of the company
- Name of the plan
- Do you plan to replace your current Medicare supplement policy with this MediQ65 policy? Y/N

[if yes]

Contact a MediQ65 Sales Representative to request the Notice of Replacement Questionnaire.

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?)  Yes  No

[if yes]

- Name of the carrier
- Are you still covered under this policy?
- Start Date
- [if NO to "Are you still covered under this policy?"] End Date

[Show the following copy and 3 inputs **only** if person is 65 or older]

You must have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for MediQ65. Please provide the following information shown on your red, white and blue Medicare Health Insurance card.

Medicare Number (show image of actual Medicare Card)

			—			—					—	
--	--	--	---	--	--	---	--	--	--	--	---	--

Hospital (Part A) Effective Date (date field)

Hospital (Part B) Effective Date (date field)

**NEXT PAGE**

### Step 3A – Medical Information

Please answer the following health related questions. Acceptance of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage, Arkansas residency and our review of your answers to the medical questions.

Height

Ft	Inches

Weight

Lbs

Medicare Disabled?  Yes  No

[if yes]

- Please explain

#### Primary Care Physician

Please fill out the following information for your Primary Care Physician.

Name

Address

City

State

Zip

Date of last visit

Reason for visit

[Add another Primary Care Physician-> creates another set of inputs]

**NEXT PAGE**

### Step 3B – Medical History

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

Have you used any form of tobacco within the past 12 months?  Yes  No

[if yes]

- Type of tobacco
- Amount of use

**In the last five (5) years, have you:**

■ Had home health care services for any reason?  Yes  No

[if yes]

- Please explain

■ Required the assistance of any other individual for performances of any activities of daily living?  Yes  No

[if yes] Please check all that apply

- Bathing
- Dressing
- Transferring
- Eating
- Toileting
- Continence

■ Used any addictive or non-addictive drug or substance except as provided by a physician?  Yes  No

[if yes]

- Please explain

■ Used alcohol in amounts greater than 3 drinks per day?  Yes  No

Have you ever had inpatient or outpatient cardiac surgery or other cardiac procedures?  Yes  No

Have you ever been diagnosed and/or treated for cancer (other than skin cancer)?  Yes  No

Have you been hospitalized since turning age 65?  Yes  No

[if yes]

- How many total days were you in the hospital?

**NEXT PAGE**

**Step 3C – Medical Conditions**

For each section below, select all medical conditions that apply or select “None of the above”.

**In the past three (3) years have you been treated for, or been told you had, any of the following conditions?**

When user selects “None of the Above” in any section, the section collapses to only show the checked “None of the Above” answer. A link will show up next to the section title that says “Show all” to make all options appear again. If “None of the Above” is then unchecked, the list will expand to show all options again.

**BRAIN OR NERVOUS SYSTEM DISORDERS**

- 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 palsy
- Parkinson’s disease
- Vertigo, fainting or dizziness
- Any other disorder of the brain or nervous system

None of the above

**RESPIRATORY**

- Chronic obstructive pulmonary disease or asthma
- Obstructive or reactive airway disorder
- Home oxygen therapy
- Any other disorder of the lungs, bronchial tubes or respiratory system
- None of the above

**DIGESTIVE**

- Cirrhosis, hepatitis
- Crohn’s disease or ulcerative colitis
- Diverticulitis
- Gastric bypass surgery or other weight loss procedure
- Gastric or duodenal ulcer
- Irritable bowel syndrome
- Gastric esophageal reflux disorder (GERD)
- Pancreatitis
- Any other disorder of the stomach, intestines, liver, gallbladder or rectum

None of the above

**EARS/EYES/NOSE/THROAT**

- Cataracts or glaucoma
- Any other disorder of the eyes, ears, nose, throat or esophagus

None of the above

**GLANDULAR**

- Adrenal disorders
- Diabetes, abnormal glucose
- Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands

None of the above

**CIRCULATORY**

- Angina, heart attack, myocardial infarction, arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- Cerebrovascular accident (stroke) including transient ischemic attack (TIA)
- Chest pain, shortness of breath, heart murmur palpitation of the heart, rheumatic fever
- Heart bypass surgery, pacemaker implant
- Heart surgery
- High blood pressure
- Hemophilia
- Any other condition of the heart, blood, blood vessels or circulatory system

None of the above

**CANCER, LYMPHATIC SYSTEM, BLOOD, OR SKIN DISORDERS**

- Anemia
- Cancer
- Hodgkin’s disease

- Leukemia
- Melanoma, neoplasm or tumor
- Any other disorder of the lymphatic system
- Any other disorder of the skin

None of the above

**MUSCULOSKELETAL**

- Arthritis
- Chronic fatigue
- Connective tissue disorder
- Fracture(s) or broken bone(s) — Exposed bone?  YES  NO
- Fibromyalgia
- Lupus, systemic
- Any other disorder of the muscles, bones or joints

None of the above

**KIDNEY, URINARY, REPRODUCTIVE**

- 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

**MENTAL/EMOTIONAL OR SUBSTANCE ABUSE**

- Anxiety, depression, emotional problems or nervous disorder
- Drug overdose
- Eating disorder
- Psychiatric treatment
- Any other mental, emotional disorder or situation

None of the above

**OTHER**

- Current patient in a hospital or nursing home
- Sarcoidosis
- Any other implant(s), prosthetic device(s) internal fixation device(s) or retained hardware (i.e.. pins, wires, screws, shunts, stents)
- Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder, or HIV
- Transplant recipient
- Surgery, procedure, or test advised by physician but not completed
- Unexplained or unintentional weight loss of 10 pounds or more
- Any injury deformity, incapacitation, disease or condition not listed elsewhere

None of the above

NEXT PAGE

### Step 3D Additional Medical Information

Please provide more information about the medical conditions you selected in the previous step.

If user selected a medical condition in Step 3C, then the following set of questions will be asked for each medical condition selected.

Condition/Illness [condition/illness field pre-populated with responses from Step 3C]

Type of treatment

[dropdown: Doctor visit, Emergency room visit, Surgery Hospitalization, Chiropractic treatments, Nursing Home confinement, Rehabilitation therapy, other]

[if other]

[show textbox]

Date of first diagnosis (month/year)

Date of most recent visit (month/year)

Total # of visits

Degree of recovery

[dropdown: None, Partial, Full]

Name of Physician

Address of Physician

Zip of Physician

Name at the time of visit (e.g. a maiden name)

If the applicant whose name is listed on this application is not the name given at the time of the physician visit(s), please indicate the name given at that time.

NEXT PAGE

### Step 3E – Prescription Information

Are you currently taking any prescription medication, or have you taken prescription medication in the last three (3) years?

Yes  No

[if yes]

- Name of medication
- Dosage
- Specific condition or illness [dropdown: populated with conditions from Step 3C, and other][If other][textbox]
- Start Date
- Are you currently taking this drug?  Yes  No
  - [if no] End Date
- Degree of recovery? [dropdown: None, Partial, Full]
- Name of Physician
- Address of Physician
- Zip of Physician

Add another Prescription Drug -> creates another set of inputs

NEXT PAGE

## Step 4 – Pick Your Plan

[If user is applying during Open Enrollment period, the following message will display “Step 3 – Medical Information is not required. You are applying during Open Enrollment and do not need to complete Step 3.”]

Review our four (4) plan options and pick the plan that is right for you!

### **Plan A** [[hyperlink to PDF](#)]

[Premium based on County]

This plan provides an economical basic benefit package, including coverage benefits for hospital and physician coinsurance, extended hospital stays and more. **Plan A** benefits are core benefits or basic benefits because all other Medigap plans include these basic or core benefits within their design.

### **Plan F** [[hyperlink to PDF](#)]

[Premium based on County]

This very popular plan includes basic benefits, skilled nursing coinsurance, full payment for Part A and Part B deductibles, and a foreign travel benefit.

Then, Part B excess charges are covered at 100% to round out this as a very comprehensive benefit package.

### **Plan G** [[hyperlink to PDF](#)]

[Premium based on County]

Plan G combines full coverage of the Part A deductible with payment for Part B excess charges at 100% (member pays Part B deductible).

Plan G also includes the core benefits, skilled nursing coinsurance, and a foreign travel benefit.

### **Plan N** [[hyperlink to PDF](#)]

[Premium based on County]

This Medigap plan covers 100% of the Medicare Part A deductible. It also covers 100% of the Medicare Part B coinsurance, except up to \$20 of the copayment for office visits and up to \$50 for emergency room visits.

## Step 5 – Payment Options

**Bank Draft (monthly)** [if selected] Show authorization statement

1. I authorize QualChoice and the Bank/Financial Institution indicated below, to debit my MediQ65® premium from the account indicated below.
2. This authority is to remain in full force and effect until my Bank has received written notification from me of the Bank Draft termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it, or until the Bank has sent me ten (10) days' written notice of the Bank's termination of this agreement.
3. I understand that by revoking the Monthly Bank Draft after I have agreed to it, I will also be terminating my MediQ65® coverage, **UNLESS** QualChoice has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the Bank Draft withdrawal date.
4. I understand that if my bank rejects a draft due to insufficient funds in my account, QualChoice may charge me a fee of up to \$20.00.
5. I understand that my first month's premium will be drafted upon initial acceptance of coverage.
6. I understand that for all other premiums I may select one of two bank draft dates.

"I understand and agree"

- Select from 2 options
  - 24<sup>th</sup> of the month preceding coverage month
  - 5<sup>th</sup> of the coverage month]
- Name of Bank
- Account type:  checking  savings]
- Bank Account Number
- 9 digit bank routing number
- Account Holder Name
- Account Holder Address
- Account Holder City
- Account Holder State
- Account holder Zip

**Monthly Billing**

A \$2.00 monthly service fee applies. Your monthly invoice will be mailed to your **billing address**.

**Quarterly Billing**

- I authorize QualChoice to bill my MediQ65® premium on a quarterly basis.
- This type of billing arrangement is to remain in full force and effect until QualChoice receives written notice of my desire to change my billing arrangement.
- I must provide QualChoice notice to change my billing arrangement twenty (20) days prior to when my next premium payment is due.

[Back -> previous screen](#)

[Review Application -> continue to Review/Submit](#)

## NEXT PAGE

### Review and Submit [fields 1-8 will auto-populate from information provided in application]

1. Name of person applying
2. Phone number
3. Email address (if Go Paperless was selected)
4. Mailing address
5. Plan selected
6. Plan premium
7. Payment selected
8. Billing address

### CAREFULLY READ and REVIEW THE FOLLOWING INFORMATION.

#### Payment Authorization [info in scroll box]

I agree to all terms and conditions expressed in the payment method I have chosen. I understand that not properly following what has been authorized on this form may cause my MediQ65® policy to be terminated at QualChoice's discretion.

#### Authorization to Disclose Protected Health Information (PHI) [info in scroll box]

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 adjudicating 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 Notice of Privacy Practices.
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 photocopy 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 obtained by it about me to MIB or any member

**Important Information for Applicant [info in scroll box]**

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, 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.
- 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- 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 reinstated 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 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).

**I represent and acknowledge the following:**

1. I have read and understand the **Important Information for Applicant**.
2. I should not cancel any coverage I currently have until I am notified of QualChoice's decision.
3. 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 contact your agent/broker.
4. 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.
5. 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.
6. 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.
7. QualChoice, or a designated representative, may phone me for additional information that may help with the timely processing of my application.
8. That the statements and answers given in this application are true, complete and correctly recorded.

I, the applicant, certify that I signed this application in the state of Arkansas.

I, the applicant, or my authorized representative, acknowledges receipt of the following materials: *Choosing A Medigap Policy: A Guide to Health Insurance for People with Medicare* (hyperlink) and *Outline of Medicare Supplement Coverage* (hyperlink) from QualChoice.

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, understand and agree to the terms listed above.

Full Name

[If agent/broker]

- I have read and understand the **MediQ65® Application for Coverage**.
- I certify that the applicant has received the *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 and that the applicant has Medicare Parts A and B.
- I certify that the policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the policy applied for will not duplicate any coverage.
- Before this application can be processed:
  - the agent/broker's current health and life license must be on file with QualChoice
  - the agent/broker must be appointed with QualChoice.

I, the agent/broker, understand and agree to the terms listed above.

**Full Name**

AGENT/BROKER REQUIRED TO INPUT FULL NAME (First, Last, MI)

List 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 Start Date

Policy End Date

Add another policy -> creates another set of inputs

**[Back -> previous screen](#)**

**[Submit Application-> Submit application and go to confirmation page](#)**

NEXT PAGE

## Application Received

Thank you for submitting your MediQ65 Medicare Supplement application!

One more thing! Please send a copy of the notice from your prior insurer concerning guaranteed issue or your right to buy a Medicare supplement insurance policy to the following address. We cannot process your application until this letter is received.

QualChoice MediQ65

PO Box 25626

Little Rock AR 72221-5626

You will be contacted within the next couple of weeks with the status of your application.

Have a question?

Contact a MediQ65 Sales Representative

501.228.7111 or 855.633.4765 (855.MEDIQ65)

Monday – Friday

8 a.m. to 5 p.m.

Download Plan Benefit Information [PDF for plan that they selected]

Download Copy of your MediQ65 Application [PDF]

If applicant previously stated they have a note from a prior insurer saying they were eligible for guaranteed issue, this sentence will display.

**\*Footer on all pages**

**Disclaimer**

MediQ65 Medicare Supplement plans are not connected with or endorsed by the U.S. Government or the Federal Medicare program.

**Fair Credit Reporting Act**

In connection with your application for insurance an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to:

QualChoice MediQ65  
Underwriting Division  
PO Box 25626  
Little Rock, AR 72221-5626

MediQ65 Medicare Supplement plans are underwritten by QualChoice Life and Health Insurance Company, Inc. MediQ65 Medicare Supplement Plans are not connected with or endorsed by the U.S. government or the federal Medicare program.