THE INSURANCE CODE OF 1956 (EXCERPT)
Act 218 of 1956

500.3827 Duplicate benefits prohibited; application; statements and questions whether another policy in force; list of policies sold to applicant; notice regarding replacement coverage.

Sec. 3827. (1) A Medicare supplement insurance policy or certificate must not be delivered or issued for delivery in this state if the policy or certificate provides benefits that duplicate benefits provided by Medicare.

(2) Application forms or a supplementary application or other form to be signed by the applicant and agent for Medicare supplement policies, which may be provided in written or electronic format, must include the following statements and questions designed to inform and elicit information as to whether, on the date of the application, the applicant has Medicare supplement, Medicare advantage, Medicaid coverage, or another health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any health policy or certificate presently in force:

[STATEMENTS]

(1) You do not need more than 1 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) If you are 65 or older, 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 will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days after 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 after losing Medicaid eligibility. If the Medicare supplement 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.

(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 after 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 Medicaid.

[QUESTIONS]

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.

[Please mark Yes or No below with an "X"]

To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months?
Yes ____ No ____

(b) Did you enroll in Medicare part B in the last 6 months?
Yes ____ No ____

(c) If yes, what is the effective date? _____

(2) 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.]

Yes _____ No _____

If yes,

(a) 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) (a) 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 or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

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?

Yes _____ No _____

(c) Was this your first time in this type of Medicare plan?

Yes _____ No _____

(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan?

Yes _____ No _____

(4) (a) Do you have another Medicare supplement policy in force?

Yes _____ No _____

(b) If so, with what company, and what plan do you have [optional for direct mailers]?

_____

(c) If so, do you intend to replace your current Medicare supplement policy with this policy?

Yes _____ No _____

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)

Yes _____ No _____

(a) If so, with what company and what kind of policy?

_____

_____

_____

_____

(b) What are your dates of coverage under the other policy?

START __/__/__ END __/__/__

(If you are still covered under the other policy, leave "END" blank.)

(3) An agent shall list on the application form for a Medicare supplement policy any other health insurance policies, certificates, or contracts he or she has sold to the applicant, including policies, certificates, or contracts sold that are still in force and policies, certificates, and contracts sold in the past 5 years that are no longer in force.

(4) For a direct response insurer, the insurer shall return a copy of the application or supplement form, signed by the applicant, and acknowledged by the insurer, to the applicant on delivery of the policy or certificate.

(5) On determining that a sale will involve replacement of Medicare supplement coverage, an insurer, other than a direct response insurer or its agent, shall furnish the applicant before issuance or delivery of the Medicare supplement policy the following notice regarding replacement of Medicare supplement coverage.

One copy of the notice signed by the applicant and the agent, unless the coverage is sold without an agent, must be provided to the applicant and an additional signed copy must be retained by the insurer. A direct response insurer shall deliver to the applicant at the time of issuance of the policy or certificate the following notice, regarding replacement of Medicare supplement coverage. The notice regarding replacement of Medicare supplement coverage must be provided in substantially the following form and in not less than 12-point type:

"NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT COVERAGE OR MEDICARE ADVANTAGE
(INSURANCE COMPANY'S NAME AND ADDRESS)
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to (your application) (information you have furnished), you intend to drop or otherwise terminate existing Medicare supplement coverage or Medicare advantage plan and replace it with a policy or certificate to be issued by (company name) insurance company. Your new policy or certificate provides 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

You should review this new coverage carefully comparing it with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by insurer, agent, or other representative:

(Use additional sheets as necessary.)

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate your existing Medicare supplement, or, if applicable, Medicare advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare advantage plan, to the best of my knowledge. The replacement policy is being purchased for the following reasons (check 1):

_____ Additional benefits

_____ No change in benefits, but lower premiums

_____ Fewer benefits and lower premiums

_____ My plan has outpatient prescription drug coverage and I am enrolling in part D

_____ Disenrollment from a Medicare advantage plan. Please explain reason for disenrollment. [Optional only for direct mailers.]

_____ Other. (Please specify)

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy. This paragraph may be deleted by an insurer if the replacement does not involve application of a new pre-existing condition limitation.

2. Your insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage. This paragraph may be deleted by an insurer if the replacement does not involve application of a new preexisting condition limitation.

3. If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded. (If the policy or certificate is guaranteed issue, this paragraph need not appear.)

4. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

Signature of Agent, Broker, or Other Representative
(* Signature not required for direct response sales.)

_____

Typed Name and Address of Agent or Broker

_____

(Date)

The above "Notice to Applicant" was delivered to me on:

_____

(Date)

_____

(Applicant's Signature)

_____

(Applicant's Printed Name)

_____

(Applicant's Address)

(Policy, Certificate, or Contract Number being Replaced)"

History: Add. 1992, Act 84, Imd. Eff. June 2, 1992;—Am. 2006, Act 462, Imd. Eff. Dec. 20, 2006;—Am. 2018, Act 429, Eff. Mar. 20, 2019.

Popular name: Act 218