wpsmedicaresolutions.com

FOR USE WITH EFFECTIVE DATES OF 9/1/2025 OR LATER

Please use the postage-paid envelope provided or mail completed application to:

WPS
Attn: Medicare Supplement Sales
1717 W. Broadway | P.O. Box 8190 | Madison, WI 53708-8190 Or fax this completed document to 1-608-223-3639

MEDICARE SUPPLEMENT PLAN ENROLLMENT APPLICATION

INSTRUCTIONS: You may not apply more than three (3) months prior to becoming eligible for coverage. Please complete all information requested on this application and mail this entire form to the address above. If application is being completed through an agency, the agent must complete and submit the agency form (section 10 of this application). You must have Medicare Parts A and B to enroll. If you have other Medicare supplement insurance that you don't intend to cancel, you are not eligible for this Medicare supplement plan.

Reason for application: ❍ Initial enrollment ❍ Re-enrollment ❍ Adding riders ❍ Removing riders ❍ Adding dental

1. APPLICANT INFORMATION

Last name_____ First _____ Middle _____

Date of birth_____ Gender _____

Home address _____

City _____County _____ State _____ ZIP code _____

Mailing address (if different)_____

City _____County _____ State _____ ZIP code _____

Telephone number (_____) _____Email address _____

Medicare number _____

Medicare Part A effective date _____ Medicare Part B effective date _____

Do you currently reside in the same household* with someone other than yourself who meets either of the following conditions?

1. They are age 60 or older, and you have continuously lived with them for the last 12 months; OR
2. They are currently enrolled in or applying for a WPS Medicare Supplement plan?

❍ Yes ❍ No

If yes, provide household member's Full Name _____ Date of Birth _____

If answering yes based on 2, provide the household member's Medicare number_____

Effective date of WPS Medicare supplement policy_____

2. PLAN EFFECTIVE DATE

If WPS approves you for coverage under this Medicare supplement policy, the policy's effective date will be the latest of:

A. The first day of the calendar month in which you become enrolled in Medicare Part B; or

B. The first day of the calendar month following the date of WPS approval; or

C. Requested effective date _____/01/_____ (must be the first of the month)

*Household: Two or more individuals who reside together in the same dwelling. For purposes of this definition, "dwelling" means a single home, condominium unit, or apartment unit within an apartment complex.

3. PLAN SELECTION

A. Select a basic plan below

B. Add optional riders	❑ **BASIC PLAN ONLY** Highest coverage option	❑ **BASIC PLAN WITH COPAY/COINSURANCE RIDER** Second-highest coverage option
Medicare Part A Deductible	❍100% or ❍50%	❍100% or ❍50%
Medicare Part B Excess Charges	❍	❍
Additional Home Health Care	❍	❍
Foreign Travel*	❍	❍
Additional rider only available to applicants first eligible for Medicare before 1/1/2020		
Medicare Part B Deductible	❍	

*Effective date (if adding after initial enrollment)_____

C. Add optional dental plan
❍ Dental plan underwritten by Delta Dental of Wisconsin
(If you select this option but currently have dental coverage with another carrier, you must cancel that other dental coverage in order to be eligible for coverage by Delta Dental of Wisconsin.)

> **NOTICE**: If you are only adding the dental plan or removing optional riders, you may skip to **section 7**.

4. GUARANTEED ACCEPTANCE

Please answer the following questions to determine whether your acceptance is guaranteed, without answering health questions.

A. Did you turn 65 within the last six months? ..... ❍ Yes ❍ No

B. Did you enroll in Medicare Part B within the last six months? ..... ❍ Yes ❍ No

If yes, what is the Medicare Part B effective date? _____/_____/_____

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 proceed to section 6.

If you answered yes to questions A or B above, your acceptance is guaranteed, and you should not answer health questions. Please proceed to section 6. If you answered no to questions A or B, and you are not losing other coverage, please proceed to section 5 to answer health questions.

There are other scenarios that may qualify you for guaranteed acceptance into this Medicare supplement plan, when you lose or terminate health coverage under certain circumstances. You may find a full list of qualifying guaranteed-issue scenarios in *Wisconsin Guide to Health Insurance for People with Medicare*. If you have any question whether you qualify for guaranteed acceptance into this Medicare supplement plan, please contact us or speak with your agent.

5. HEALTH QUESTIONS

A. Have you been diagnosed, received treatment or had any of the following in the past **two years**?... ❍ Yes ❍ No

- Hospitalized (more than 24 hours) three times or more, or been recommended to have inpatient surgery that hasn't yet been performed?
- Hospitalized for the treatment of mental or nervous disorders, including alcohol or drug abuse?
- Diabetes; Liver disease; Macular degeneration; Connective tissue disorder; or broken bones due to osteoporosis?
- Heart related:
  - Aneurysm
  - Carotid artery disease
  - Congestive heart failure
  - Coronary artery disease (hardening or narrowing of the artery or arterial blockage)
  - Enlarged heart
  - Heart attack
  - Heart rhythm disorder
  - Heart Valve disorder
  - Peripheral vascular disease
  - Pulmonary heart disease
  - Pulmonary hypertension
  - Stroke

B. Have you been diagnosed or received treatment for any of the following in the past **five years**?..... ❍ Yes ❍ No

- Kidney disease, kidney dialysis or end-stage renal disease (ESRD)?
- Cancer (except for non-melanoma skin cancer)?
- Had or been recommended to have any organ transplant other than of the cornea?

C. Have you been diagnosed with or received treatment for any of the following **at any time**? ..... ❍ Yes ❍ No

- Alzheimer's disease
- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease)
- Cerebral palsy
- Cystic fibrosis
- Emphysema
- Hemophilia
- Multiple sclerosis
- Muscular dystrophy
- Myasthenia gravis
- Parkinson's disease
- Rheumatoid arthritis
- Sickle cell anemia
- Systemic lupus

D. Do any of the following statements **currently** describe you?..... ❍ Yes ❍ No

- I am confined to a nursing facility; I am hospitalized; or I am enrolled in a hospice program.

STOP: If you answered yes to questions A, B, C, or D in this section, you are not eligible for this Medicare supplement plan at this time. If you need assistance answering these health questions, please contact us or speak with your agent.

If you answered no to questions A, B, C, and D in this section, please proceed to section 6.

6. YOUR CURRENT COVERAGE

A. Please review the important statements below.

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

- If you are eligible for and have enrolled in a Medicare supplement or Medicare Cost 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 or Medicare Cost 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 or Medicare Cost policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement or Medicare Cost policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement or Medicare Cost policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement or Medicare Cost 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).

B. Please answer the following questions about Medicaid coverage.

- 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 you answered no, please skip to question C.
If you answered yes, please answer the following questions.

- Will Medicaid pay your premiums for this Medicare supplement policy? ..... ❍ Yes ❍ No
- Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ..... ❍ Yes ❍ No

C. Please answer the following questions about Medicare replacement coverage.

- Have you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, Medicare HMO or PPO)? ..... ❍ Yes ❍ No

If you answered no, please skip to question D.
If you answered yes, please answer the following questions.

- Please fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

  START ___/___/____ END ___/___/____

- 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
- Was this your first time in this type of Medicare plan? ..... ❍ Yes ❍ No
- Did you terminate a Medicare supplement policy to enroll in the Medicare plan? ..... ❍ Yes ❍ No

D. Please answer the following questions about Medicare supplement coverage.

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

If you answered no, please skip to question E.
If you answered yes, please answer the following questions.

- With what company is your policy, and what type of plan do you have?

_____

- Do you intend to replace your current Medicare supplement policy with this policy? ..... ❍ Yes ❍ No

E. Please answer the following questions about other health insurance.

- 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 you answered no, please skip to section 7.
If you answered yes, please answer the following questions.

- With what company, and what type of policy?

_____

- Please fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

  START ___/___/____ END ___/___/____

7. ACCEPTANCE/AGREEMENT

***NOTE**: Signature on this agreement does not authorize disclosure of information prohibited under section 631.90, Wisconsin statutes.*

By my signature below, I understand and agree that all statements and answers I've given are complete and true to the best of my knowledge, and that the policy for which I'm applying will be effective only after WPS approves this application. Evidence of such approval will be issuance of the policy.

I understand WPS may release information about me to its representative(s) or other person(s) or organization(s) performing business or legal services in connection with my claims and as otherwise permitted by law. WPS does not disclose protected health information in this application to entities that are not subject to the Privacy Rule unless those entities are under a Business Associate Agreement with WPS requiring use and disclosure in accordance with the Privacy Rule.

I understand that an insurance agent or broker cannot modify or waive the terms, conditions, or provisions of the insurance policy, application or requirement imposed by WPS, nor bind coverage or guarantee approval of coverage. I further understand that WPS, its directors, officers, employees, and agents shall not be liable for any injury, damage, or expense (including attorneys' fees) I suffer as a result of any improper advice, action, or omission on the part of any health care provider.

I understand that the insurer fully complies with the regulations and orders regarding doing business with foreign countries or foreign nationals listed on the Office of Foreign Assets Control's Specially Designated Nationals and Blocked Persons (SDN) list. Therefore, the insurer may rescind and void any coverage if it determines that I am either listed on the SDN list or associated with an entity listed on the SDN list.

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'm applying for a Medicare supplement policy. I've considered all factors and believe this Medicare supplement policy suits my needs. I received the Medicare supplement outline of coverage and the booklet entitled *Wisconsin Guide to Health Insurance for People with Medicare* before applying for this policy.

This application is not complete unless signed and dated.
IMPORTANT: Please read and sign section 8 if you are replacing a current Medicare supplement or Medicare Advantage policy with this policy.

➡X _____ _____

Applicant's signature Date

8. IF YOU ARE REPLACING COVERAGE, READ AND SIGN THIS SECTION

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT, MEDICARE COST, MEDICARE SELECT, MEDICARE ADVANTAGE, OR EXISTING ACCIDENT AND SICKNESS INSURANCE

Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway, Madison, WI 53713
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or information you have furnished, you intend to terminate existing Medicare supplement, Medicare Cost, Medicare Select, or Medicare Advantage plan and replace it with a policy to be issued by Wisconsin Physicians Service Insurance Corporation. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement, Medicare Cost, Medicare Select, or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement, Medicare Select, or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION, AGENT, BROKER, OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement, Medicare Cost, Medicare Select, or Medicare Advantage policy will not duplicate your existing Medicare supplement, Medicare Cost, Medicare Select, or Medicare Advantage coverage because you intend to terminate your existing Medicare supplement, Medicare Cost, Medicare Select coverage, or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ❍ Additional benefits
- ❍ Fewer benefits and lower premiums
- ❍ No change in benefits, but lower premiums
- ❍ Other (please specify) _____
- ❍ My plan has outpatient prescription drug coverage, and I am enrolling in Medicare Part D
- ❍ Disenrollment from a Medicare Advantage plan
  Please explain reason for disenrollment _____

1. Note: If the issuer of the Medicare supplement policy being applied for does not impose, or is otherwise prohibited from imposing, pre-existing condition limitations, please skip to Statement 2 below. Health conditions that 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.
2. State law provides that your replacement policy may not contain new pre-existing condition waiting periods. The insurer will waive any time periods applicable to pre-existing condition waiting periods in the new policy (or coverage) for similar benefits to the extent such time was satisfied under the Medicare supplement policy.
3. If you still wish to terminate your present policy 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 requested material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy 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 reported.

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*

_____

(Printed name and address of issuer, agent, or broker) Agency number

➡X _____ _____

Applicant's signature Date

9. PREMIUM PAYMENT OPTIONS

Please check ONE of the three options.

❑ AUTOMATIC BANK WITHDRAWAL: We electronically transfer your premium directly from your bank account at the frequency you request. When you select this option, **you save 2% on your premium**.

A. Account information

Select one: ❍ I am attaching a voided check to the bottom of this page → **Tape voided check below as shown, then skip to B.**

❍ I will provide the bank account information

Bank name _____

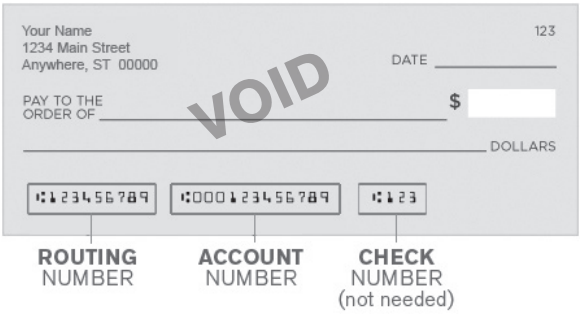
9-digit routing number_____

Account number _____

Type of account:

❍ Checking

❍ Savings (Your savings account number may be found on a bank statement or by contacting your bank)



B. Account holder information

Name _____

Address _____

City _____ State _____ ZIP code _____

C. Frequency and timing of payments

Select one: ❍ Monthly ❍ Quarterly ❍ Semiannually ❍ Annually

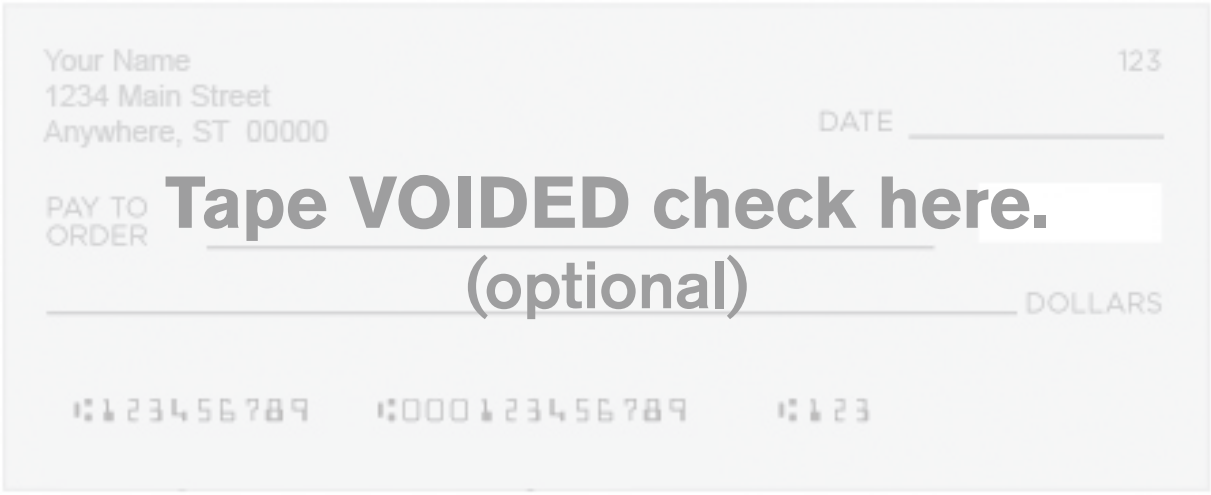
Select one: ❍ On the 1st of the coverage month ❍ On the 20th of the month prior to coverage

D. Authorization and signature

By my signature below, I authorize Wisconsin Physicians Service Insurance Corporation (WPS) to instruct my financial institution to deduct my premium payments from the account designated above. I authorize my financial institution to debit the amount of my premium from my designated account. This authorization will remain in effect until I notify WPS in writing of its termination. My notification must afford WPS and my financial institution reasonable opportunity to act on it. WPS is not responsible for any loss, incorrect delivery, destruction, delay, or interception of this application and its contents by others.

Sign Here ➡ X _____ _____

Applicant's signature Date



9. PREMIUM PAYMENT OPTIONS (CONTINUED)

❑ DIRECT BILL: We send a premium notice directly to your home at the frequency you request. You return payment to WPS by the premium due date.

❑ CREDIT/DEBIT CARD: You may set up credit or debit card payments by visiting pay.wpsic.com. Please note that if you do not set up a payment within 5 business days of receipt of your application, you will automatically be enrolled in the monthly direct bill option listed above.

BILL FREQUENCY:

❍ Monthly ❍ Quarterly ❍ Semiannually ❍ Annually

Note: If you choose either of these options, you miss an opportunity to save 2% on your premium.

10. AGENCY FORM

If application is being completed through an agent, he or she must complete the following section.

A. Please list any other health insurance policies you have personally sold to the applicant that are still in force. (If none, please write none.) Also, list any policies you sold to the applicant in the past five (5) years that are no longer in force.

POLICY DESCRIPTION	IN FORCE
_____	❍ Yes ❍ No
_____	❍ Yes ❍ No
_____	❍ Yes ❍ No

B. I asked the applicant all the questions in this application, and the answers are recorded as given to me. ..... ❍ Yes ❍ No

Signed at _____ Date ____ /____/____

Writing agent (print name) _____

Signature of writing agent _____

Agency name _____

Tax ID number _____

Neither Wisconsin Physicians Service Insurance Corporation nor its agents are connected with the federal Medicare program. Our products are not connected with or endorsed by the United States government or the federal Medicare program. WPS complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, disability, or sex.

WPS™ A HEALTH SOLUTIONS COMPANY

1717 W. Broadway
P.O. Box 8190
Madison, WI 53708-8190

DELTA DENTAL®