



Indiana

MEMBERS HEALTH INSURANCE COMPANY

Home Office: P.O. Box 1424, Columbia, TN 38402-1424, 1-888-708-0123

GENERAL INFORMATION

Thank you for your interest in enrolling for Medicare Supplement Insurance under the Indiana Farm Bureau Group. Please read the following guidelines carefully to assist you in completing the application.

- To apply for this Medicare Supplement Insurance, you must be age 65 or older and enrolled in Medicare Part A and Part B.**
- An Indiana Farm Bureau membership is required for enrollment under the group policy. If you do not currently have an Indiana Farm Bureau membership, please also complete and submit an Indiana Farm Bureau Membership Application and Agreement, a bank draft authorization form for the annual membership dues, and a separate check for \$32.50 payable to Indiana Farm Bureau Inc. for your initial membership dues. All future membership dues will be drafted from your checking account after a 15-day notice from the Indiana Farm Bureau Home Office.**
- Please check your enrollment application for accuracy and be sure to sign your first and last name beside any corrections. Prompt return of any additional documents requested will prevent unnecessary delays in the underwriting process.
- IF YOU HAVE CURRENT COVERAGE, DO NOT CANCEL YOUR CURRENT COVERAGE UNTIL YOU HAVE BEEN ISSUED A CERTIFICATE OF COVERAGE (the "Certificate") BY US AND UPON REVIEW, AGREE TO ACCEPT THE PREMIUM, TERMS AND CONDITIONS OF THE NEW CERTIFICATE.**
- If approved for coverage, you will be mailed a billing statement for the initial amount due. This billed amount must be paid by the due date. **Once the billed amount has been paid, each monthly billing thereafter will be by automatic draft from your bank account. The automatic withdrawal from your bank account will occur on or after the 1st of each month.**
- MHI Medicare Supplement Insurance is age-rated. Your premium will be based on your current age and will be adjusted annually with each birthday. In addition, overall general premium adjustments may be necessary. You will be notified by letter 30 days in advance of any premium adjustment.
- Your Plan Identification Card ("ID card") and Certificate should arrive within a few days of your initial billing. Please review both the ID card and the Certificate carefully, as they contain important information about your coverage. If you find that you are not satisfied with your Certificate for any reason, you may return it to us. If you send the Certificate back to us within 30 days after you receive it, we will treat the Certificate as if it had never been issued and return all of your payments, less any claims paid.

Please refer to Open Enrollment and Guaranteed Issue information on the back side of this page.



OPEN ENROLLMENT

You are eligible for open enrollment if you are applying within six (6) months of turning age 65 or obtaining Medicare Part B, whichever occurs last. If you are in your open enrollment period, have not had a break in coverage of 63 days or more, and at the time of application can provide proof of prior continuous creditable coverage of at least six (6) months, the pre-existing condition waiting period will be waived. If your prior continuous creditable coverage is less than six (6) months, the pre-existing condition waiting period will be reduced by the number of months prior continuous creditable coverage existed.

GUARANTEED ISSUE

You may qualify for the guaranteed issue of Plans A, B, C or F if you apply within 63 days of losing other coverage and you:

- Are in a Medicare Advantage plan (also known as Medicare Part C) and the plan is leaving the Medicare program, discontinues plans in your area, or you move out of the Medicare Advantage plan's service area;
- Are in original Medicare (Medicare Part A and Part B) and have coverage through an employer group health plan (including retiree or COBRA) or union plan that pays after Medicare pays, and the employer group health plan or union plan terminates;
- Joined a Medicare Advantage plan when you first became eligible for Medicare Part A at age 65 and within twelve (12) months of joining, you decide you want to switch to original Medicare;
- Dropped your Medicare Supplement Insurance to join a Medicare Advantage plan for the very first time, have been in the Medicare Advantage plan less than twelve (12) months, and want to switch back to original Medicare; or
- Are age 65 or older with Medicare and are disenrolled from Medicaid.

Documentation verifying your circumstances will be required.

Please Note:

There may be other circumstances that qualify you for the guaranteed issue provision. Please consult with our Home Office regarding your circumstances at 1-888-708-0123, 7 a.m. - 5 p.m., Central Time. If you are not eligible for guaranteed issue, a six (6) month pre-existing condition waiting period may apply if you are approved for coverage.



MEMBERS HEALTH INSURANCE COMPANY

Home Office: P.O. Box 1424, Columbia, TN 38402-1424, 1-888-708-0123

Indiana

ENROLLMENT APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE COVERAGE

Group Policy Number: 127001

Group Policyholder: Indiana Farm Bureau

PLEASE PRINT CLEARLY AND USE BLACK INK

SECTION 1 - INSURED PERSON (OWNER)

First Name		MI	Last Name		FOR OFFICE USE ONLY		
Street Address						Effective Date	
City	County	State	Zip Code		ID Number		
Primary Phone No. () _____ - _____ Best time to call _____ AM/PM					Rating Action:		
Alternate Phone No. () _____ - _____ Best time to call _____ AM/PM							
Email Address (Optional)							
Social Security Number		Date of Birth (mm/dd/yyyy)		Marital Status (Optional)		Gender	
				<input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widowed		<input type="checkbox"/> Male <input type="checkbox"/> Female	

Yes No

Are you an existing Indiana Farm Bureau member? If "No," please submit an Indiana Farm Bureau Membership Application and Agreement.

Indiana Farm Bureau membership is in the name of: _____

Indiana Farm Bureau membership number: _____

SECTION 2 - MEDICARE SUPPLEMENT INSURANCE PLAN SELECTION

Select Medicare Supplement Insurance Plan (check one plan)

Plan A Plan B Plan C Plan D Plan F Plan G Plan M Plan N

SECTION 3 - IMPORTANT COVERAGE INFORMATION

Please Read Carefully

- (1) You do not need more than one Medicare Supplement Insurance plan.
- (2) If you purchase this Medicare Supplement Insurance plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- (3) You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Insurance plan.



Indiana

Last Name	First	MI
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- (4) If, after purchasing this Medicare Supplement Insurance plan, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement Insurance plan 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 Insurance plan (or, if that is no longer available, a substantially equivalent Medicare Supplement Insurance plan) will be reinstated if requested within 90 days of losing Medicaid eligibility.
- (5) If you are eligible for, and have enrolled in a Medicare Supplement Insurance plan 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 Insurance plan can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement Insurance plan under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement Insurance plan (or, if that is no longer available, a substantially equivalent Medicare Supplement Insurance plan) will be reinstated if requested within 90 days of losing your employer or union-based group health plan.
- (6) Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement Insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

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 Medicare Supplement Insurance, or that you had certain rights to buy such insurance, you may be guaranteed acceptance in one or more of the Medicare Supplement Insurance plans offered under the Indiana Farm Bureau group policy. Please include a copy of the notice from your prior insurer with your application.

SECTION 4 - GENERAL QUESTIONS

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

Yes No

- 1. Did you turn age 65 in the last six (6) months?

Yes No

- 2. Are you enrolled in Part A (Hospital) of Medicare?

(a) If **"Yes,"** please enter your name, ID number (with letter designation) and effective date exactly as it appears on your Medicare card:

Name _____ ID Number _____

Effective Date ____/____/____

(b) If **"No,"** give your expected effective date ____/____/____

Yes No

- 3. Did you enroll in Medicare Part B in the last six (6) months?

(a) If **"Yes,"** what is the effective date? ____/____/____

If you are not enrolled in Medicare Part A and Part B, you are not eligible to apply for this Medicare Supplement Insurance.



Last Name	First	MI
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Yes No

4. 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

(a) If "Yes," will Medicaid pay your premiums for this Medicare Supplement Insurance?

Yes No

(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

SECTION 5 - OTHER COVERAGE INFORMATION

Yes No

1. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a Medicare HMO or PPO)?

If "Yes," fill in your start and end dates and answer the questions below.

Please Note: Your original start date may not be the date on your current ID card with the other plan. If you are still covered under the plan, leave the "END DATE" blank.

START DATE_____/_____/_____ END DATE_____/_____/_____

Yes No

(a) If you are still covered under the above Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement Insurance?

Yes No

(b) Was this your first time in this Medicare plan?

Yes No

(c) Did you cancel Medicare Supplement Insurance to enroll in the Medicare plan?

Yes No

2. Do you have other Medicare Supplement Insurance in force?

If "Yes," answer the following question:

(a) With what company? _____

(b) What Medicare Supplement Insurance plan do you have? _____

Yes No

(c) Do you intend to replace your current Medicare Supplement Insurance with this plan?



Last Name	First	MI
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Yes No

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

If "Yes," answer the following question:

(a) With what company and what kind of policy? _____

(b) What are your dates of coverage under the other policy? (If you are still covered under the policy, leave "END DATE" blank.)

START DATE _____ / _____ / _____ END DATE _____ / _____ / _____

Yes No

4. Do you intend to replace your current health care coverage with this Medicare Supplement Insurance?

SECTION 6 - MEDICAL QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

If you are applying within six (6) months of turning age 65 or obtaining Medicare Part B, whichever occurs last, you do not have to answer these questions.

In the last five (5) years, have you been treated for any of the following medical conditions:

Yes No	If "Yes," when?
<input type="checkbox"/> <input type="checkbox"/> 1. Heart Attack or Congestive Heart Failure?	_____
<input type="checkbox"/> <input type="checkbox"/> 2. Cancer (Not Skin Cancer)?	_____
<input type="checkbox"/> <input type="checkbox"/> 3. Stroke or Trans Ischemic Attack (TIA)?	_____
<input type="checkbox"/> <input type="checkbox"/> 4. Kidney Failure or Disease?	_____
<input type="checkbox"/> <input type="checkbox"/> 5. Diabetes?	_____
<input type="checkbox"/> <input type="checkbox"/> 6. Parkinson's Disease?	_____
<input type="checkbox"/> <input type="checkbox"/> 7. Multiple Sclerosis or Lou Gehrig's Disease (ALS)?	_____
<input type="checkbox"/> <input type="checkbox"/> 8. Muscular Dystrophy?	_____

Please list any prescription drugs (print full medication name) you are currently taking:

1. _____ 2. _____ 3. _____ 4. _____
 5. _____ 6. _____ 7. _____ 8. _____



Indiana

Last Name	First	MI
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SECTION 7 - ACKNOWLEDGMENTS AND AGREEMENTS

Please Read Carefully.

I understand and acknowledge:

Members Health Insurance Company ("MHI") is entitled to rely solely on the statements made on this enrollment application to be complete and correct to the best of my knowledge and beliefs.

I understand and acknowledge that the Medicare Supplement Insurance plan which may be issued:

- Will be effective, subject to all the terms and conditions of the Certificate, upon approval of my enrollment application by MHI; the effective date will be indicated on my ID card and in my Certificate.
- Shall be binding only if each statement included on the enrollment application is complete and true to the best of my knowledge.

I understand and acknowledge the following:

- If my enrollment application is not submitted during an open enrollment period or guaranteed issue period, MHI has the right to reject my application and any premiums paid will be refunded.
- I understand that this Medicare Supplement Insurance will not pay for benefits for hospital confinement beginning or medical expenses incurred during the first six (6) months of coverage if they are due to conditions for which medical advice was given or treatment recommended by a physician within six (6) months prior to the effective date of my Certificate. Coverage is not limited if I satisfy creditable coverage requirements.
- I have received an Outline of Coverage. I understand that the "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare" publication will be provided with my Certificate.
- I have the right to examine the Certificate. If I find that I am not satisfied with the Certificate, I may return it to MHI. If I send the Certificate back to MHI within 30 days after I receive it, MHI will treat the Certificate as if it had never been issued and return all of my payments to me less any claims paid.
- Premium for my Certificate will be based on my current age and will be adjusted annually with each birthday.

I authorize any doctor, hospital, clinic, provider of health care, insurance or reinsurance company, or any other person or firm having any information necessary to determine my eligibility for coverage under the group policy, to give all such information to MHI. I (or my personal representative) may request a copy of this authorization.

I understand the information in this enrollment application and any information obtained with this authorization will be used by MHI to determine eligibility for coverage and that coverage will be affected by this information. I understand that this authorization is valid for 24 months.



Indiana

Last Name	First	MI
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I declare that all the foregoing statements provided by me in this enrollment application in its entirety are true, correct and complete to the best of my knowledge and beliefs.

I, the undersigned applicant, certify that I have read, or have had read to me, this completed application and that I realize that any false statement or misrepresentation in this enrollment application may result in voidance of my Certificate.

If your age has been misstated in the enrollment application, we will adjust the premium to reflect the amount that should have been paid based on your correct age. If your age has been misstated in the enrollment application and, if based on your correct age this Medicare Supplement Insurance plan would not have been issued, we will refund premium paid, less the amount of any claims paid, and the Certificate will be considered never to have been issued.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an enrollment application for insurance may be guilty of a crime and may be subject to fines and confinement in prison, and it may result in denial of coverage under the group policy.

Date _____

Applicant Signature_____

This enrollment application is not acceptable unless completely filled out and signed. A scanned, imaged or photocopied version of this completely executed form will have the same force and effect as the original document.

Please send one signed and dated copy of this enrollment application to our Home Office at P.O. Box 1424, Columbia, TN 38402-1424. Retain one signed and dated copy of this enrollment application for your records.

If you would prefer to email a scanned version of the enrollment application and applicable forms, please contact our Home Office for assistance at 1-888-708-0123.



INSTRUCTIONS FOR BANK DRAFT AUTHORIZATION FORM

The following must be completed to authorize your automatic bank draft after you pay the initial paper invoice.

1. **Signature of Applicant/Insured** (Required) – Applicant/Insured must sign and date that he/she agrees to the terms and conditions as set forth in the Bank Draft Authorization.
2. **Signature of Payor** (Required) and **Print Payor Name** (Required) – Payor (owner/signatory of account) must sign and print name.
3. If draft is to occur on a personal account, please check “**Personal Account**” and indicate “**Checking**” or “**Savings**” account.
4. If draft is to occur on a business account, check “**Business Account.**” Please indicate if Applicant/Insured is an owner of the business by checking the appropriate box. If not, please indicate if Applicant/Insured is an active employee of the business by checking the appropriate box. We cannot accept business account information for an active employee.
5. Please attach voided check to bottom of form if bank account is checking. **Deposit slips will not be accepted.** If savings account, please complete the requested information fully and accurately. There will be a \$25 fee on any returned bank drafts due to incorrect information you have submitted.
6. Please be sure to include this form with your completed application and mail to Members Health Insurance Company, P.O. Box 1424, Columbia, TN 38402-1424.

Please note: Federal law prohibits an employer from making payment for a Medicare Supplement Plan for an active employee.



BANK DRAFT AUTHORIZATION FORM

I hereby authorize Members Health Insurance Company ("MHI") to initiate debit entries from the account identified below for the monthly payment of premium for my Medicare Supplement Insurance. The depository named below is authorized to debit the same to my account. I acknowledge I am authorized to sign this agreement on behalf of all covered individuals and signatories to the account. I further understand I have the right to revoke this authorization by notifying MHI in writing at least ten (10) days prior to the time payment is due and my account is charged in order to give MHI a reasonable opportunity to act upon it. I further agree that should a debit be dishonored, whether with or without cause and whether intentionally or inadvertently, MHI shall have no liability whatsoever, even if such dishonor results in forfeiture of coverage.

Print Applicant/Insured Name (Required)

Print Payor Name (Required)

Signature of Applicant/Insured (Required)

Signature of Payor (Required)

Date

Identification Number

PERSONAL ACCOUNT - Checking Savings

BUSINESS ACCOUNT

1. Applicant/Insured is owner of business Yes No

2. If no, Applicant/Insured is an active employee Yes No

PLEASE READ CAREFULLY

For Checking Accounts: Attach voided check here (No Deposit Slips)

For Savings Account: Fill out requested information completely and accurately. (No Deposit Slips)

Name and Address of Financial Institution

Routing Number

Account Number

Signature, Authorized Representative of Financial Institution

Telephone Number

Cancellation - Applicant/Insured may cancel this Policy for any reason by giving ten (10) days written notice to Members Health Insurance Company: such notice is to be sent to our Home Office. The Policy will remain in effect until the paid-to date. Please see your Policy for specific information regarding cancellations and cancellations due to death of Applicant/Insured.



NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

MEMBERS HEALTH INSURANCE COMPANY

Home Office: P.O. Box 1424, Columbia, TN 38402-1424, 1-888-708-0123

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your enrollment application, you intend to terminate existing Medicare Supplement or Medicare Advantage Insurance and replace it with a Certificate to be issued by Members Health Insurance Company. Your new Certificate will provide thirty (30) days within which you may decide without cost whether you desire to keep the Certificate.

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 purchase of this Medicare Supplement Insurance is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage Insurance. You should evaluate the need for other accident and sickness coverage you have that may duplicate this Certificate.

STATEMENT TO APPLICANT BY INSURANCE COMPANY

We have reviewed your current medical or health insurance coverage. To the best of our knowledge, this Medicare Supplement Insurance will not duplicate your existing Medicare Supplement Insurance or, if applicable, Medicare Advantage Insurance because you intend to terminate your existing Medicare Supplement Insurance or leave your Medicare Advantage Insurance. The replacement Certificate is being purchased for the following reasons (check one):

- 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 the reason for disenrollment:

- Other (please specify). _____

(1) State law provides that your replacement Certificate may not contain new pre-existing conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new Certificate to the extent such time was spent (depleted) under the original policy.

(2) 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 enrollment application concerning your medical and health history. Failure to include all material medical information on an enrollment application may provide a basis for the company to deny any future claims and to refund your premium as though your Certificate had never been in force. After the enrollment application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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

MEMBERS HEALTH INSURANCE COMPANY

Home Office: P.O. Box 1424, Columbia, TN 38402-1424, 1-888-708-0123

Applicant's Signature _____

Date _____



HIPAA AUTHORIZATION

Plan Type: Indiana Farm Bureau Group Medicare Supplement Insurance

Applicant Name: _____ **Address:** _____

SS#: _____ **DOB:** _____ **City/State/Zip:** _____

I hereby authorize the use or disclosure of protected health information (“PHI”) about me as described below:

1. I authorize Members Health Insurance Company (“MHI”) to use **the PHI I have provided on the application form to determine my initial and continued eligibility to obtain coverage under the Medicare Supplement Insurance plan for which I have applied, to determine the rates and terms which apply to the plan and for the purpose of compliance with its agreement to provide Medicare Supplement Insurance plans to members of Indiana Farm Bureau, Inc.**
2. The following group of persons employed or working for MHI may use or disclose my PHI, which is described above: **Employees involved in accounting and membership services processes.**
3. The information which is disclosed by MHI shall be disclosed only to **Indiana Farm Bureau, Inc.,** and solely for the limited purposes identified in this authorization.
4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by MHI in reliance on this authorization, by sending a written revocation to: **MHI, Attn: Privacy Office, P.O. Box 1424, Columbia, TN 38402-1424; Fax: 931-388-8326.**
5. This authorization will expire one hundred eighty (180) days *after* I have dis-enrolled from or become ineligible to participate in this group Medicare Supplement Insurance plan.
6. I understand that the information which will be provided under this authorization is necessary for MHI to fulfill its obligation to provide Medicare Supplement Insurance plans to members of Indiana Farm Bureau, Inc., and that MHI will condition enrollment and eligibility in the health benefits plan/policy on my providing this authorization, and my application may be denied and/or eligibility revoked, if I refuse to provide this authorization or revoke this authorization.
7. I understand that if the person or entity that receives my PHI is not a health care provider or a health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulation. ***I have been advised, however, that MHI and Indiana Farm Bureau, Inc. have entered into a confidentiality agreement with regard to any PHI used or disclosed by MHI to Farm Bureau, Inc. for the purpose defined above.***

Applicant Name (or Legal Representative)

Signature

Date



MEMBERS HEALTH INSURANCE COMPANY

PERSONAL REPRESENTATIVE DESIGNATION

You have the right to request that Members Health Insurance Company ("MHI") give another person access to your protected health information. To do so, please complete this form along with your signature and return it to the MHI Privacy Office. You may revoke this designation at any time with written notice to MHI.

INSURED INFORMATION (Required) - PLEASE PRINT

First Name: _____ MI: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: ___/___/___ Social Security #: _____ - _____ - _____ Identification #: _____

Telephone: _____ E-mail Address: _____

PERSONAL REPRESENTATIVE - PLEASE PRINT

First Name: _____ MI: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: ___/___/___ Telephone: _____ Relationship to Insured: _____

ADDITIONAL REPRESENTATIVE (OPTIONAL) - PLEASE PRINT

First Name: _____ MI: _____ Last Name: _____

Address: _____ City, State, Zip: _____

Date of Birth: ___/___/___ Telephone: _____ Relationship to Insured: _____

SIGNATURE (Required)

I request the person(s) named above be allowed access to my protected health information. I understand that I may revoke this designation at any time by submitting a written notice to MHI.

INSURED SIGNATURE: _____ DATE: _____

If the member is unable to sign because of a physical or mental condition, the person completing this form must sign below. Documentation of the condition should be submitted with this form. If you are signing with Power of Attorney, a complete copy of the Power of Attorney must accompany this form.

SIGNATURE OF LEGAL REPRESENTATIVE

RELATIONSHIP TO INSURED

DATE

In order to process this designation, this form must be complete and signed by the insured. Incomplete forms will not be accepted. Return this form to the MHI Privacy Office, P.O. Box 1424, Columbia, TN 38402-1424.

For questions, call the MHI Privacy Office at 1-888-708-0123
YOU ARE ENTITLED TO A COPY OF THIS REQUEST.



MEMBERS HEALTH INSURANCE COMPANY

Checklist for applying for Medicare Supplement Insurance

The Members Health Insurance Company ("MHI") Medicare Supplement Insurance enrollment application is not acceptable unless completely filled out and signed and all applicable documents are submitted. The following checklist has been provided to assist you with the accuracy and completion of your enrollment application and the application process.

- Complete SECTION 1 with your current information.
- If you are not currently an Indiana Farm Bureau member, complete the Indiana Farm Bureau Membership Application and Agreement form, a bank draft authorization form for the annual membership dues, and a separate check for \$32.50 payable to Indiana Farm Bureau for your initial membership dues.
- In SECTION 2, select the Medicare Supplement Insurance plan of your choice.
- In SECTION 4, answer ALL QUESTIONS "YES" or "NO," and provide all information applicable to these questions.
- In SECTION 5, answer ALL QUESTIONS "YES" or "NO," and provide all applicable information regarding other coverage you have.
- In SECTION 6, answer ALL HEALTH QUESTIONS and list ALL medications you are currently taking.
- In SECTION 7, read carefully and be sure to sign and date the enrollment application.
- Complete all sections of the MHI Bank Draft Authorization (including payor information).
- You must read and sign the HIPAA Authorization. An enrollment application submitted without a signed HIPAA Authorization will not be accepted.
- You must submit a copy of your Medicare card.
- If you so choose, you may complete and sign the Personal Representative Designation. Completion of the Personal Representative Designation is not required.

Once you have completed the above checklist and reviewed your enrollment application and applicable forms for accuracy, please mail the following information to our Home Office at P.O. Box 1424, Columbia, TN 38402-1424. If you would prefer to email a scanned version of the enrollment application and applicable forms, please contact our Home Office for assistance at 1-888-708-0123.

REQUIRED DOCUMENTS FOR SUBMISSION

- ◇ Completed Group Medicare Supplement Insurance enrollment application
- ◇ Completed MHI Bank Draft Authorization
- ◇ Completed HIPAA Authorization
- ◇ Copy of your Medicare card
- ◇ Copy of your completed Replacement Form
- ◇ Indiana Farm Bureau Membership Application and Agreement, a bank draft authorization form for the annual membership dues, and a separate check for \$32.50 payable to Indiana Farm Bureau for your initial membership dues (if applicable).

If you have any questions or need assistance, please contact our Home Office at 1-888-708-0123, 7 a.m. - 5 p.m., CST. You may also go to www.mhinsurance.com for additional information.

REMINDER: Retain one signed and dated copy of the MHI Medicare Supplement Insurance enrollment application and Replacement Form.



Members Health Insurance Company

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY & KEEP ON FILE FOR REFERENCE.

LEGAL OBLIGATIONS

Members Health Insurance Company (MHIC) is required by law to maintain the privacy of all medical information within its organization; provide this notice of privacy practices to all members; inform members of our legal obligations; and advise members of additional rights concerning their medical information. MHIC must follow the privacy practices contained in this notice from its **effective date of April 26, 2011**, and continue to do so until this notice is changed or replaced.

MHIC reserves the right to change its privacy practices and the terms of this notice at any time, provided applicable law permits the changes. Any changes made in these privacy practices will be effective for all medical information that is maintained including medical information created or received before the changes were made. All members will be notified of any changes by receiving a new notice of privacy practices.

You may request a copy of this notice of privacy practices at any time by contacting Ryan D. Brown, MHIC, Chief Compliance and Privacy Officer, P.O. Box 1424, Columbia, TN 38402-1424.

USES AND DISCLOSURES OF MEDICAL INFORMATION

Your medical information may be used and disclosed for treatment, payment and health care operations. For example:

TREATMENT: Your medical information may be disclosed to a doctor or hospital that requests it to provide treatment to you or for disease and case management programs.

PAYMENT: Your medical information may be used or disclosed to pay claims for services which are covered under your health care coverage.

HEALTH CARE OPERATIONS: Your medical information may be used and disclosed to determine premiums, conduct quality assessment and improvement activities, to engage in care coordination or case management, to pursue Right of Recovery and Reimbursement/Subrogation, accreditation, conducting and arranging legal services, underwriting and rating, and for other administrative purposes.

AUTHORIZATIONS: You may provide written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke this authorization in writing at any time but this revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

PERSONAL REPRESENTATIVE: Your medical information may be disclosed to you or to a family member, friend or other person to the extent necessary to assist with your health care or with payment for your health care but only if you agree we may do so or if they have the legal right to act for you, as described in the Individual Rights section of this notice.

UNDERWRITING: Your medical information may be received for underwriting, premium rating or other activities relating to the creation, renewal, or replacement of health care coverage or benefits. If MHIC does not issue that health care coverage, your medical information will not be used or further disclosed for any purpose, except as required by law.

RESEARCH: Your medical information may be used or disclosed for research purposes provided that certain established measures to protect your privacy are in place.

MARKETING: Your medical information may be used to contact you with information about health-related benefits, services or treatment alternatives that may be of interest to you. Your medical information may be disclosed to a business associate to assist us in these activities. Unless the information is provided to you by a general newsletter or in person or is for products or services of nominal value, you may opt-out of receiving further information by telling us.

AS REQUIRED BY LAW: Your medical information may be used or disclosed as required by state or federal law. For example, we will use and disclose your PHI in responding to court and administrative orders and subpoenas, and to comply with workers' compensation laws. We will disclose your PHI when required by the Secretary of Health and Human Services and state regulatory authorities.

COURT OR ADMINISTRATIVE ORDER: Medical information may be disclosed in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances.

MATTERS OF PUBLIC INTEREST: Medical information may be released to appropriate authorities under reasonable assumption that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. Medical information may be released to the extent necessary to avert a serious threat to your health or safety or to the health or safety of others. Medical information may be disclosed when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody. Medical information may be disclosed for purposes of child abuse reporting.

MILITARY AUTHORITIES: Medical information of Armed Forces personnel may be disclosed to Military authorities under certain circumstances. Medical information may be disclosed to federal officials as required for lawful intelligence, counterintelligence, and other national security activities.

BUSINESS ASSOCIATES: From time to time we engage third parties to provide various services for us. Whenever an arrangement with such a third party involves the use or disclosure of your PHI, we will have a written contract with that third party designed to protect the privacy of your PHI. For example, we may share your information with business associates who process claims or conduct disease management programs on our behalf.

INDIVIDUAL RIGHTS

You have the following rights. To exercise these rights, you must make a written request on our standard form. To obtain the form, call 1-888-708-0123. Forms are also available at www.mhinsurance.com.

ACCESS: You have the right to receive or review copies of your medical information, with limited exceptions. You may request a format other than photocopies, which will be used unless the company cannot practicably do so. Any request to obtain access to your medical information must be made in writing. You may obtain a form to request access by using the contact information at the end of this notice or you may send us a letter requesting access to the address located at the end of this notice. If you request copies, there will be a charge of \$.25 per page and \$10 for staff time to review, copy and prepare your medical information, and postage if you want the copies mailed to you. If your PHI is maintained in an electronic health record ("EHR") you also have the right to request that an electronic copy be sent to you or to another individual or entity. The fee for providing an electronic copy may not be greater than our labor costs in responding to your request for such a copy. If you request an alternative format, the charge will be cost-based for providing your medical information in that format. For a more detailed explanation of the fee structure, please contact our office using the information at the end of this notice. MHIC requires advance payment before copying your medical information.

ACCOUNTING: You have the right to receive an accounting of the disclosures of your medical information made by our company or by a business associate of our company. This accounting will list each disclosure that was made of your medical information for any reason other than treatment, payment, health care operations and certain other activities since April 14, 2003; however, if disclosures for purposes of treatment, payment, or health care operations were made through an EHR, you have the right to request an accounting for such disclosures made during the previous three years. This accounting will include the date the disclosure was made, the name of the person or entity the disclosure was made to, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If you request an accounting more than once in a 12-month period, there may be a

reasonable cost-based charge for responding to these additional requests. For a more detailed explanation of the fee structure, please contact our office using the information at the end of this notice.

DESIGNATION OF PERSONAL REPRESENTATIVE: You have the right to designate a family member, friend or other person as your personal representative. Your medical information may be disclosed to your personal representative to the extent necessary to help with your health care or with payment for your health care. You may obtain a form to designate a personal representative by using the contact information at the end of this notice.

RESTRICTIONS ON DISCLOSURES: You have the right to request restrictions on the company's use or disclosure of your medical information. Generally the company is not required to agree to these additional requests. If you paid out-of-pocket for a specific item or service, you have the right to request that medical information with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. Any agreement to restrictions on the use and disclosure of your medical information must be in writing and signed by a person authorized to make such an agreement on behalf of the company; such restrictions shall not apply to disclosures made prior to granting the request for restrictions. The company will not be bound unless the agreement is so memorialized in writing.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications about your medical information by alternative means or alternative locations. You must inform the company that confidential communication by alternative means or to an alternative location is required to avoid endangering you. You must make your request in writing and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location requested. The company must accommodate the request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premium and pay claims under your health plan.

AMENDMENT: You have the right to request that the company amend your medical information. Your request must be in writing and it must explain why the information should be amended. The company may deny your request if the medical information you seek to amend was not created by our company or for certain other reasons. If your request is denied, the company will provide a written explanation of the denial. You may respond with a statement of disagreement to be appended to the information you wanted amended. If the company accepts your request to amend the information, the company will make reasonable efforts to inform others, including the people you name, of the amendment and to include the changes in any future disclosures of that information.

BREACH NOTIFICATION: You have the right to receive notice of a breach. We are required to notify you by first class mail or by e-mail (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

- A brief description of the breach, including the date of the breach and the date of its discovery, if known;
- A description of the type of Unsecured PHI involved in the breach;
- Steps you should take to protect yourself from potential harm resulting from the breach;
- A brief description of the actions we are taking to investigate the breach, mitigate losses, and protect against further breaches;
- Contact information, including a toll-free telephone number, e-mail address, Web site, or postal address to permit you to ask questions or obtain additional information.

In the event the breach involves 10 or more patients whose contact information is out of date we will post a notice of the breach on the home page of our Web site or in a major print or broadcast media. If the breach involves more than 500 individuals in the state or jurisdiction, we will send notices to prominent media outlets. If the breach involves more than 500 individuals, we are required to immediately notify the Secretary of Health and Human Services. We also are required to submit an annual report to the Secretary of Health and Human Services of a breach that involves less than 500 individuals during the year and we will maintain a written log of breaches involving less than 500 patients.

If you receive this notice on the MHIC web site or by any other electronic means, you may request a written copy of this notice by using the contact information at the end of this notice.

COMPLAINTS, QUESTIONS AND CONCERNS

If you want more information concerning the companies' privacy practices or you have questions or concerns, please contact our Privacy Office.

If you are concerned that: (1) the company has violated your privacy rights; (2) you disagree with a decision made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information; (3) to request that the company communicate with you by alternative means or at alternative locations, you may complain to us using the contact information below. You may also submit a written complaint to the U.S. Department of Health and Human Services. The address to file a complaint with the U.S. Department of Health and Human Services will be provided upon request.

The company supports your right to protect the privacy of your medical information. There will be no retaliation in any way if you choose to file a complaint with Members Health Insurance Company or with the U.S. Department of Health and Human Services.

**The Privacy Office
Members Health Insurance Company
147 Bear Creek Pike, Columbia, TN 38401
Phone 1-888-708-0123
E-mail: privacyoffice@mhinsurance.com**

04/2012