



ADMINISTRATIVE RULES OF MONTANA



6.6.510 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE

- (1) Application forms must include the following questions designed to elicit information as to whether, as of the date of application, the applicant currently has Medicare supplement, Medicare advantage, Medicaid coverage, or another health policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and producer containing such questions and statements as the following may be used.

(STATEMENTS)

- (1) You do not need more than one 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) 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 must 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. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. 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 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 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 prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- (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).

(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 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.)

[End Statements and Questions Form]

(2) Producers shall list any other health insurance policies they have sold to the applicant, including:

- (a) Policies sold which are still in force; and
- (b) Policies sold in the past five years which are no longer in force.

(3) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

(4) Upon determining that a sale will involve replacement of medicare supplement coverage, and prior to the issuance or delivery of the medicare supplement policy or certificate, an issuer, other than a direct response insurer, or its producer must furnish the applicant a notice regarding replacement of medicare supplement coverage. One copy of the notice signed by the applicant and the producer, except where coverage is sold without a producer, must be provided to the applicant and an additional signed copy must be retained by the issuer for three years. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of medicare supplement coverage.

(5) The notice required by (4) for an issuer must be in substantially the same form as below and be in no less than 12 point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT

OF MEDICARE SUPPLEMENT INSURANCE

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 terminate existing Medicare or Medicare advantage supplement insurance and replace it with a policy to

be issued by (Company Name). Your new policy will provide 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. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement or Medicare advantage coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, OR PRODUCER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will 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. The replacement policy is being purchased for the following reason(s) (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 reason for disenrollment.
[optional only for direct mailers.]

Other. (please specify)

1. Note: If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to statement

(2) below. 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.

2. State law provides that your replacement policy or certificate may not contain new preexisting 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 policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original 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/health history. Failure to include all 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 recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

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

(Signature of Producer or Other Representative)*

[Typed Name and Address of Issuer or Producer]

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

(Date)

(Applicant's Signature)

*Signature not required for direct response sales.

[END OF NOTICE FORM]

- (6) Paragraphs 1. and 2. of the replacement notice, above (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

Authorizing statute(s): 33-1-313, 33-22-904, 33-22-907, MCA

Implementing statute(s): 33-15-303, 33-22-904, 33-22-907, 33-22-921, 33-22-922, 33-22-923, 33-22-924, MCA

History: NEW, 1981 MAR p. 1474, Eff. 2/1/82; AMD, 1990 MAR p. 1688, Eff. 9/1/90; AMD, 1993 MAR p. 1487, Eff. 7/16/93; AMD, 1996 MAR p. 1637, Eff. 1/1/97; AMD, 1998 MAR p. 3269, Eff. 12/18/98; AMD, 2004 MAR p. 313, Eff. 2/13/04; AMD, 2005 MAR p. 1910, Eff. 9/9/05; AMD, 2018 MAR p. 572, Eff. 3/17/18.