MICHIGAN

Medigap Subsidy

Medigap assistance for people who qualify

Tell us about the people applying for the subsidy.
If more than 2 people in your household are applying, please call us at 1-866-824-9772.

Applicant 1

First name	Middle name	Last name	Suffix (examples: Sr., Jr., III, IV)

Date of birth (MM/DD/YYYY)	Social Security Number (SSN)
Gender ☐ Male ☐ Female	Medicare Health Insurance Claim Number (HICN)

Home address — Apartment or suite number

City	State	ZIP Code	County

Home phone number

☐ Check here if mailing address is the same as home address. If it is not the same, fill in below.

Mailing address — Apartment or suite number

City	State	ZIP Code	County

Medigap coverage Check the box next to the applicant's insurer and tell us the policy information.

☐ Blue Cross Blue Shield of Michigan
☐ Blue Care Network
☐ UnitedHealthcare AARP® Medicare Supplement
☐ Priority Health
☐ Other insurer_____

Policy number
AARP number (for UnitedHealthcare only)
Policy start date (MM/DD/YYYY)
Policy end date (MM/DD/YYYY)

Benefits Check the box next to the benefits the applicant receives and tell us the program number. If the applicant has any of these benefits, they may automatically qualify for the subsidy.

☐ SNAP (food stamps) Number:
☐ Michigan Low Income Energy Assistance Program (LIHEAP) Number:
☐ Medicare Savings Program for Part A or B premium assistance (QMB, SLMB, or QI only) Number:

QUESTIONS?

Call us at **1-866-824-9772**
(TTY: 1-866-824-7002)
Monday to Friday, 8:00 a.m. to 6:00 p.m.
The call is free.

Go to **MichiganMedigapSubsidy.com**

The Michigan Medigap Subsidy is a program of the Michigan Health Endowment Fund.
To learn more, go to HealthEndowmentFund.org.

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Applicant 2

First name | Middle name | Last name | Suffix (examples: Sr., Jr., III, IV)

Date of birth (MM/DD/YYYY)

Social Security Number (SSN)

Gender
☐ Male ☐ Female

Medicare Health Insurance Claim Number (HICN)

Medigap coverage Check the box next to the applicant's insurer and tell us the policy information.

☐ Blue Cross Blue Shield of Michigan

☐ Blue Care Network

☐ UnitedHealthcare AARP® Medicare Supplement

☐ Priority Health

☐ Other insurer_____

Policy number

AARP number (for UnitedHealthcare only)

Policy start date (MM/DD/YYYY)

Policy end date (MM/DD/YYYY)

Benefits Check the box next to the benefits the applicant receives and tell us the program number. If the applicant has any of these benefits, they may automatically qualify for the subsidy.

☐ SNAP (food stamps) Number:

☐ Michigan Low Income Energy Assistance Program (LIHEAP) Number:

☐ Medicare Savings Program for Part A or B premium assistance (QMB, SLMB, or QI only) Number:

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Skip this page if any of the applicants have any of the benefits listed on page 1.

Tell us about your household.

If none of the applicants have the benefits listed on page 1, we need more information about your household.

Household income

Check **one** box that applies to you for your 2015 tax return.
For the box you check, fill in the information requested.

☐ I filed **Form 1040 US** (Individual Income Tax Return)

Adjusted Gross Income from Line 37:

☐ I filed **Form MI 1040 CR** (Michigan Homestead Property Tax Credit)

Total Household Resources from Line 28:

☐ I filed **Form MI 1040 CR-7** (Michigan Home Heating Credit)

Total Household Resources from Line 30:

☐ I did **not** file a tax return for 2015. My income comes from:

Social Security benefits	Amount: $	☐ Monthly ☐ Yearly
IRA distributions	Amount: $	☐ Monthly ☐ Yearly
Pension distributions	Amount: $	☐ Monthly ☐ Yearly
Other sources	Amount: $	☐ Monthly ☐ Yearly

Household members

Members of your household are those people who live with you and are claimed on your tax return if you file one. Fill in their information below. Include all members of your household even if they are not applying for the subsidy. If you have more than 2 people in your household, please call us at 1-866-824-9772.

Person 1

First name	Middle name	Last name	Suffix (examples: Sr., Jr., III, IV)

Date of birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

Person 2

First name	Middle name	Last name	Suffix (examples: Sr., Jr., III, IV)

Date of birth (MM/DD/YYYY)	Gender ☐ Male ☐ Female

QUESTIONS?

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Choose someone to be the main contact for this application.
We will call or send information to the main contact.
This can be an applicant, a member of your household, or someone else.

Main contact

First name	Middle name	Last name	Suffix (examples: Sr., Jr., III, IV)

Date of birth	Gender ☐ Male ☐ Female

Home address	Apartment or suite number

City	State	ZIP Code	County

Home phone number

Cell phone number

☐ Check here if mailing address is the same as home address. If it is not the same, fill in below.

Mailing address	Apartment or suite number

City	State	ZIP Code	County

By filling in information about the main contact, you agree that:

- The main contact can speak and act for all the applicants on this application.
- The applicants are responsible for the accuracy of the information the main contact gives us.
- We can contact the main contact and discuss any of the applicants' personal information.

By signing this application, you acknowledge that:

- The information you provided is true and accurate to the best of your knowledge.
- The information you provided is given voluntarily.
- At any time, you may refuse to provide any of the information requested. But any missing information may affect your ability to receive the subsidy.

The information you provide will be kept confidential. As a part of the application process, we may share your information with your Medigap insurer. They are also required to protect your information.

Signature

▶	Date

QUESTIONS?

Call us at **1-866-824-9772**
(TTY: 1-866-824-7002)
Monday to Friday, 8:00 a.m. to 6:00 p.m.
The call is free.

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Before you send! Please send the following proofs with your application:

1. Proof of residency
2. Proof of benefits **or** proof of income

Proofs

1. Proof of residency

For each applicant, please send a copy of **one** of the following:

- A valid Michigan driver's license
- Michigan state ID card
- Michigan voter registration

2. Proof of benefits

If **any** of the applicants have any of the benefits listed below, please send proof. For each applicant, send a copy of the first page of the latest statement for **one** of the following:

- SNAP
- Michigan Low Income Energy Assistance Program (LIHEAP)
- Medicare Savings Program for Part A or B premium assistance (QMB, SLMB, or QI only)

or

2. Proof of income

If **none** of the applicants have the benefits listed on the left, please send proof of income for your household. Send a copy of the first page of **one** of the following:

- 1040 US (Individual Income Tax Return)
- Form MI 1040 CR (Michigan Homestead Property Tax Credit)
- Form MI 1040 CR-7 (Michigan Home Heating Credit)

If **none** of the applicants filed a 2015 tax return, please send proof of other income sources for your household. Send a copy of the first page of the latest statements for the following, as applicable:

- Social Security benefits
- IRA distributions
- Pension distributions
- Other sources

If you do **not** have statements, send us a copy of your 1099, bank statement, or any other document that shows your income.

Mail the application and proofs

Please mail your completed application and proofs to us. Use the envelope provided. Send them to:

Michigan Medigap Subsidy
P.O. Box A3413
Chicago IL 60690-9901

QUESTIONS?

Call us at **1-866-824-9772**
(TTY: 1-866-824-7002)
Monday to Friday, 8:00 a.m. to 6:00 p.m.
The call is free.

Go to
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Medigap Cost Comparison Chart

Michigan Medicare/Medicaid Assistance Program
Otsego County Commission on Aging
Advocacy Department
989-732-9977

Medigap Plan ID Letter	Company: Phone: Monthly Premium	Company: Phone: Monthly Premium	Company: Phone: Monthly Premium
A			
B			
C			
D			
F			
G			
K			
L			
M			
N			

NOTES:

Companies Offering Medigap Policies

COMPANY NAME	CONTACT INFORMATION
Transamerica Life Insurance Company	**1-888-433-9110** 4333 Edgewood RD NE Cedar Rapids, IA 52499 www.transamericaMS.com
Physicians Mutual Insurance Co.	**1-800-228-9100** P.O.Box 3313 Omaha, NE 68102 www.pmic.com
Continental General Insurance Company *Owned by Cigna	**1-877-293-8499** 11200 Lakeline Blvd., Suite 100 Austin, TX 78717 www.continentalgeneral.com
WPS Health Insurance *This company also has an option for individuals under 65 (Medigap C Coverage Only)	**1-800-811-1670** 1717 W. Broadway P.O.Box 8190 Madison, WI 53706-8190 www.wpsic.com
Mutual of Omaha Insurance Company *Ask about household 12% discount	**1-800-680-8435** Mutual of Omaha Plaza Omaha, NE 68175 www.mutualofomaha.com
State Farm Mutual Auto Insurance Co.	**1-866-855-1212** One State Farm Plaza Bloomington, IL, 61710 www.statefarm.com
United American Insurance Co. (AARP) *Ask About Their Community Rated Plan	**1-800-331-2512** 3700 S. Stonebridge Drive, P.O. Box 8080 Mckinney, TX 75070 www.UnitedAmerican.com
Order of Commercial Travelers of America	**1-800-848-0123** 632 North Park Street Columbus, OH 43215

For More Information Regarding Companies Offering Medigap Insurance Contact **www.medicare.gov**

*Your Local Auto or Homeowners Insurance Companies May Also Offer Medigap Policies. Contact your Local Agent For More Information

Medigap Policy Benefits at a Glance

Medigap Benefits	Medigap Plans									
	A	B	C	D	F*	G	K	L	M	N
Part A hospital coinsurance & hospital costs up to an additional 365 hospital days after Medicare benefits are used up	X	X	X	X	X	X	X	X	X	X
Medicare Part B Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X**
Blood (First 3 Pints)	X	X	X	X	X	X	50%	75%	X	X
Part A Hospice Care Coinsurance or Copayment	X	X	X	X	X	X	50%	75%	X	X
Part A Deductible		X	X	X	X	X	50%	75%	50%	X
Part B Deductible			X		X					
Part B Excess Charges					X	X				
Skilled Nursing Care Coinsurance			X	X	X	X	50%	75%	X	X
Foreign Travel Emergency (Up to Plan Limits)			80%	80%	80%	80%			80%	80%
Out-of-Pocket Limits***	N/A	N/A	N/A	N/A	N/A	N/A	$4,960	$2,480	N/A	N/A

*Plan F offers a high deductible option. The deductible increases every year. Premiums are typically lower than other Medigap policies. However, you must meet a $2,480 deductible in 2016 before the policy will cover your health claims.

**Plan N pays 100% of the Part B Coinsurance except up to $20 copayment for office visits and up to $50 for emergency department visits that do not result in inpatient admission.

***After you meet your out-of-pocket yearly limit and your yearly Part B deductible, the Medigap plan pays 100% of covered services for the rest of the calendar year.