MEDICARE SUPPLEMENT
ADMINISTRATIVE OFFICE
[P.O. Box 2209, Duncan, OK 73534-2209]
Telephone: [800-366-8354]

Reinstatement Application for Medicare Supplement Insurance

Type or Print clearly and use blue or black ink.

1 Insured Information

Full name of applicant *First, M.I., Last*

Policy number to be reinstated | Telephone number

1. Within the past 6 months, have you been medically diagnosed, treated, been prescribed medication for, or had surgery for any illness or injury? ☐ Yes ☐ No
2. Have you been advised by a medical professional to have tests, surgery, treatment or further evaluation for any illness or injury or are there any tests pending? ☐ Yes ☐ No
3. Are you taking or have you been advised to take any prescribed medications? ☐ Yes ☐ No

2 Details of "Yes" Answers

Please use an additional sheet of paper if needed for additional injury/illness.

Date | Type of injury or illness

Fully recovered? ☐ Yes ☐ No | Doctor/Hospital | Medication taken

Date | Type of injury or illness

Fully recovered? ☐ Yes ☐ No | Doctor/Hospital | Medication taken

Date | Type of injury or illness

Fully recovered? ☐ Yes ☐ No | Doctor/Hospital | Medication taken

Date | Type of injury or illness

Fully recovered? ☐ Yes ☐ No | Doctor/Hospital | Medication taken

3 Applicant

If this policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application for reinstatement has been approved by the Company. If we reject your Reinstatement Application, we will return the monies you submitted with your Reinstatement Application.

I hereby apply to Montana Health Co-Op for reinstatement of my lapsed policy to be reinstated in reliance on my written answers to the questions on this application. I have read and understand all statements and answers and certify that to the best of my knowledge and belief they are true, complete and correctly recorded. I agree that, if my policy is reinstated, such reinstatement shall be in accordance with the terms of the policy and shall not take effect until this application of reinstatement and the premium payment accompanying this application have been accepted and approved by the Company.

It is further agreed that reinstatement of this policy, if granted by the Company, shall be contestable for fraud or misrepresentation of any material facts stated in, or in connection with, this application for two years after the date of reinstatement.

Any person who, knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, is guilty of insurance fraud.

Signature of applicant | Date signed

X

City | State | Zip