

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 Medicare Health Insurance Claim Number (HICN)

Male Female

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 or Contract ID number
 AARP number (for UnitedHealthcare only)

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) Case 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:
 Medicare Low Income Subsidy / Extra Help for prescriptions
 VA Pension with Aid & Attendance or Housebound Benefits

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

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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 or Contract ID number

AARP number (for UnitedHealthcare only)

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SNAP (food stamps) Case 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 2016 tax return. For the box you check, fill in the information requested.

I filed **Form 1040 US** (Individual Income Tax Return). Please tell us all 3 amounts:

Adjusted Gross Income from Line 37:

Social security benefits from Line 20a:

Taxable amount from Line 20b:

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 2016. 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 Relationship
 Male Female Self Spouse Authorized Representative Guardian

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.

Applicant signature

 Date

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Before you send! Please send proof of benefits **or** income with your application.

Proofs

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)
- Medicare Low Income Subsidy (send benefit confirmation letter)
- VA Pension with Aid & Attendance or Housebound Benefits

or 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 2016 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?



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