



# The Bridge Plan Application Form Producer 04AD4 Email or Fax completed form to (480)813-9930 or info@gninsurance.com

To be eligible for the Bridge Plan coverage, you must not be eligible for Medicare. **If you have been a legal resident of the USA for five years, you are eligible to purchase Medicare and you should not complete this application.** Benefits are subject to all terms, limitations and conditions outlined in your certificate. Please read your certificate carefully once you receive it.

Applicant's Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Sex:  Male  Female  
 Residence Address: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
 Are You a US Citizen?:  Yes  No Length of Time Residing in the USA: \_\_\_\_\_  
 Requested Start Date: \_\_\_\_\_ Date you expect to be eligible for Medicare: \_\_\_\_\_  
 Deductible Amount:  1,000  1,500  2,500  5,000  10,000  
 Coverage Type:  Bridge Part A & B  Bridge Part A Only  Bridge Part B Only  
 Last healthcare provider seen: a. Date and reason last seen: \_\_\_\_\_  
 b. Results of last visit: \_\_\_\_\_

If "Yes" is answered, please provide full details in the area provided below or attach a separate page if needed

1. Do you intend to engage in sports or any other pastimes that expose you to extra personal injury?  Yes  No
2. Have you ever been declined or accepted on special terms for life, accident or illness insurance?  Yes  No
3. Have you ever had any abnormal tests or blood work that have required additional evaluation or treatment?  Yes  No
4. Have you ever been evaluated or treated for any injury, condition or disorder involving the following?  Yes  No
 

<ol style="list-style-type: none"> <li>a. Eyes/Ears <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>b. Gout <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>c. Skin <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>d. Hernia <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>e. Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>f. HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>g. Sleep apnea <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>h. Gall bladder <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>i. Concussions <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>j. Chronic Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>k. Lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>l. Cancer/Growth <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>m. High blood pressure <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>n. Heart/Chest Pain/Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol>	<ol style="list-style-type: none"> <li>o. Back/spine/neck <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>p. Throat/Thyroid/Glands <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>q. Bones/Bone Density <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>r. Arthritis/Joints (Hips Knees, Shoulders) <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>s. Fainting/Dizziness/Unconsciousness <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>t. Fatigue/Tiredness/Paralysis/Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>u. Nervous System/Alzheimer's/Dementia <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>v. Mental/Emotional/Psychiatric <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>w. Respiratory System/Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>x. Circulatory system <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>y. Reproductive system <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>z. Gastrointestinal System <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>aa. Urinary system/Prostate <input type="checkbox"/> Yes <input type="checkbox"/> No</li> <li>ab. Any other condition not listed above <input type="checkbox"/> Yes <input type="checkbox"/> No</li> </ol>
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5. Has your weight changed in the past year?  Yes  No
6. Have you ever undergone a surgical operation?  Yes  No
7. Have you taken any medicines in the past 12 months?  Yes  No
8. Have you ever been recommended to have any procedure(s), exam(s), treatment(s), and/or test(s) that have not been completed?  Yes  No
9. Other than the medical conditions noted on this application, I am in good health.  Yes  No
10. Do you need any assistance to perform activities of daily living (feeding, bathing, dressing)?  Yes  No

Questions # \_\_\_\_\_ Dates & Details: \_\_\_\_\_  
 Questions # \_\_\_\_\_  
 Questions # \_\_\_\_\_  
 Questions # \_\_\_\_\_

### DECLARATION

I declare that the above statements are true and complete. I am in good health and ordinarily enjoy good health. I agree that this proposal shall form the basis of the contract should the insurance be effected and any misstatements above may be grounds for rescission. I understand that this is a temporary insurance policy designed to reimburse the insured person for medical expenses incurred during the policy period and a new period of insurance is only available at the option of the underwriter and is subject to a new pre-existing condition exclusion. I understand the terms and conditions of this product. I also understand that since this is a temporary policy it is exempt from the Patient Protection and Affordable Care Act (PPACA) so pre-existing conditions are not covered by this policy.

Proposed Insured \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Please Print

**This plan is not compliant with the Affordable Care Act**