McLaren MEDICARE
SUPPLEMENT

McLaren Medicare Supplement
Plans A, C*, D, F*, High Deductible-F*, G, High Deductible-G and N
Application

*Plans C, F, High Deductible-F are only available to those Medicare eligible prior to 1/1/2020. Underwriting may apply.

1 Information about you

Please print in black or blue ink. All sections must be completed unless otherwise indicated. **Important: All pages of the application must be submitted.** All information provided will be used and disclosed only as permitted by our Notice of Privacy Practices which can be found at McLarenHealthPlan.org/MedicareSupplement. Please note that all information provided is confidential and will be used only for processing your enrollment. **Important: Please wait for confirmation of your enrollment in McLaren Medicare Supplement before canceling your other coverage.**

Last Name	First Name	Middle initial	Social Security number
Primary street address	City	State	ZIP code
Mailing street address (if different from above)	City	State	ZIP code
County	Phone number ☐ Home ☐ Cell	Alternate number (optional)	
Email address	Gender ☐ Male ☐ Female		Birth date
Number of months you reside in Michigan each year			
Medicare contract number (as shown on your Medicare red, white and blue card)			
Medicare Part A effective date	Medicare Part B effective date		
Please indicate your requested effective date (the first day of a month, month/day/year):			
Your coverage will become effective on the first day of the month following receipt of your completed application or the date specified above (if agreed to by McLaren). You will receive an I.D. card and a certificate of coverage with a letter confirming your effective date and premium.			

Family discount eligibility
You may be eligible for a discounted monthly premium if another Medicare beneficiary residing in your home has or is applying for McLaren Medicare Supplement Plan. Please check the box that applies to you:
☐ I reside with a person who is currently enrolled with a McLaren Medicare Supplement plan.
Person's Name: _____ McLaren Medicare Supplement ID number: _____
☐ I reside with a person who is in the process of applying for a McLaren Medicare Supplement plan.
Person's Name: _____

2 Choose a McLaren Medicare Supplement plan

Before you choose a McLaren Medicare Supplement option, it's important you know the following:

- You must be enrolled in Medicare Parts A and B.
- You cannot have more than one Medicare supplement plan.
- You cannot be enrolled in a Medicare supplement plan and a Medicare Advantage health plan at the same time.

continued

- You must be a permanent resident of Michigan at the time of enrollment.
- After you enroll, if you permanently move outside of Michigan or reside in Michigan for fewer than six months of every year, your premium will change to Rating Area 2.
- If you move outside of the United States or its territories, your McLaren Medicare Supplement plan will be terminated.
- Coverage will only continue provided all other eligibility requirements continue to be satisfied. Refer to the Outline of Coverage at McLarenHealthPlan.org/MedicareSupplement for the monthly cost and description of the plan.

☐ Plan A* ☐ Plan C (only available to those Medicare eligible prior to 1/1/2020) ☐ Plan D* ☐ Plan F (only available to those Medicare eligible prior to 1/1/2020) ☐ Plan HD-F (only available to those Medicare eligible prior to 1/1/2020) ☐ Plan G ☐ Plan HD-G ☐ Plan N

**If you are under age 65, you may have a special enrollment period and may be eligible to enroll in plans A, or D. You must have been insured with an insurer with major medical coverage and no longer be insured because you became eligible for Medicare or if you lose coverage under a group policy after becoming eligible for Medicare. Must request coverage within 90 days before or 90 days after the month you become eligible for Medicare. Otherwise, you must request coverage within 180 days after losing coverage under a group policy.*

3 Benefits under Medicaid

If you are eligible for benefits under Medicaid, you may not need a Medicare supplement plan.

1. Are you covered for medical assistance through the state Medicaid program?

Note: If you are participating in a spend-down program and have not met your cost share, please answer "No" to this question.

☐ **Yes:** Continue to Question 2.
☐ **No:** Skip to section 4.

2. Will Medicaid pay your premiums for this Medicare supplement plan?

☐ **Yes**
☐ **No**

Continue to Question 3.

3. Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium?

☐ **Yes: You are not eligible for this Medicare Supplement plan.**
☐ **No:** Continue to section 4.

If, after purchasing this plan, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement plan will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement plan may be available. If it is no longer available, a substantially equivalent plan will be reinstated if requested within 90 days of losing Medicaid eligibility.

continued

4 Open enrollment period and eligibility determination

The Medicare Supplement (Medigap) Open Enrollment Period is a one-time, six (6) month period when federal law allows you to purchase any Medicare Supplement policy sold in your state. It begins in the first month that you are both covered under Medicare Part B and are 65 or older. During this time period, you cannot be denied a Medicare supplement policy or charged more because of past or current health problems.

1. Are you enrolled in Medicare Part B?
   - ☐ **Yes**. Continue to Question 2.
   - ☐ **No.** You are not eligible to enroll in a Medigap plan. You must be enrolled in Medicare Part B to enroll in a Medigap plan.
2. Are you age 65 or older and did you enroll in Medicare Part B in the last 6 months?
   - ☐ **Yes.** You will be accepted into a McLaren Medicare Supplement plan with a preferred premium, skip to Section 7.
   - ☐ **No**. Continue to Question 3.
3. Are you both: • Enrolled in Part B and • Did you turn 65 in the last 6 months or will you turn 65 by or during the month of your requested effective date?*
   - ☐ **Yes.** You will be accepted into a McLaren Medicare Supplement plan with a preferred premium, skip to Section 7.
   - ☐ **No.** Continue to Question 4.
4. Are you under age 65 and enrolled in Part B due to a disability?
   - ☐ **Yes.** Continue to Question 5.
   - ☐ **No.** Skip to Section 5.
5. Are you currently enrolled in a Medicare Supplement, Medicare Advantage plan or other health insurance?
   - ☐ **Yes.** Complete the below required information, then skip to Section 6.

   Start date: _____ End date: _____ (Leave end date blank if still enrolled.)

   Current insurer: _____

   Reason for leaving (please explain): _____

   _____

   ☐ **No.** Skip to Section 6.

*If your birthday is on the 1st of the month, your Medicare-effective date is the 1st of the previous month. Please answer yes to this question.

continued

5 Guaranteed issue rights

1. Have you lost or are you losing other health coverage (for example, an employer, union or individual plan) and received a notice from your prior health plan saying you are eligible for guaranteed issue of a Medicare Supplement plan, or that you had certain rights to buy such a plan?

   ☐ **Yes.** Indicate start date: / / end date: / / (If you are still covered under the other policy, leave end date blank.)

   If you have not had coverage under any other health plan within the past 63 days, select "No".

   Reason for disenrollment: _____

   What company and what kind of policy? _____

   Please include a copy of the termination notice with this application.

   ☐ **No.**

2. Are you enrolled, or were you previously enrolled, in a Medicare Advantage plan?
   Note: one of the below reasons for disenrollment must apply to you, otherwise, select "No".

   ☐ **Yes**. Indicate start date:_____/_____/_____ end date:_____/_____/_____

   If you have not had coverage from any Medicare plan other than Original Medicare within the past 63 days, select "No".

   Reason for disenrollment (must check one):

   ☐ Plan is leaving Medicare.
   ☐ Plan is no longer offered in my area.
   ☐ You are moving out of the plan's service area.
   ☐ You replaced a Medicare supplement policy (or switched to a Medicare SELECT policy) for the first time, have been in the plan less than a year, and now wish to return to a Medicare supplement policy. This is considered a "Trial Right."
   ☐ You joined a Medicare Advantage plan (or PACE) when first eligible for Medicare Part A at 65, and within the first year of joining decided to switch to Original Medicare and join a Medicare supplement plan. This is also considered a "Trial Right."
   ☐ Company misled me or failed to follow the rules.

   ☐ **No**

Do you intend to replace your current Medicare Advantage plan with this plan?
If you are currently in an MAPD plan, and once you receive your acceptance letter for this plan, please make sure to disenroll from your current MAPD plan.

3. Are you enrolled, or were you previously enrolled, in a Medicare supplement policy?
   Note: one of the below reasons for disenrollment must apply to you, otherwise, select "No".

   ☐ **Yes**, Indicate start date:_____/_____/_____ end date:_____/_____/_____

   If yes, name the company and the plan: If yes, do you intend to replace your current Medicare Supplement plan with this plan? ☐ **YES** ☐ **NO**

   Reason for disenrollment (must check one):

   ☐ Medicare supplement plan ended through no fault of your own.
   ☐ Company misled you or failed to follow the rules.

   If none of the above reasons for disenrollment, select "No."

   ☐ **No**

   If you answered "yes" to any of the questions in section 5, skip to section 7.

continued

6 Your health information

Complete this section if you are not applying during your open enrollment or guaranteed issue period. The information you provide is confidential and will be used and disclosed only as permitted by our Notice of Privacy Practices, which can be viewed online at McLarenHealthPlan.org/MedicareSupplement.

Height: _____ft. _____ in. Weight: _____ lbs.
Have you used tobacco in any form in the past year? ☐ **Yes** ☐ **No**

1. Do any of these apply to you? Please check all that apply.

- ☐ AIDS or HIV+
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Cardiomyopathy
- ☐ Cerebral palsy
- ☐ Currently receiving dialysis
- ☐ Cystic or pulmonary fibrosis
- ☐ End stage renal disease
- ☐ Gaucher's or Pompe disease
- ☐ Growth hormone deficiency
- ☐ Hemophilia
- ☐ Hepatitis C
- ☐ Hospital inpatient within past 90 days
- ☐ Huntington's disease
- ☐ Kidney disease that may require dialysis
- ☐ Leukemia, lymphoma, malignant melanoma
- ☐ Muscular dystrophy
- ☐ Organ or bone marrow transplant
- ☐ Paraplegia, quadriplegia, or hemiplegia
- ☐ Pulmonary arterial hypertension
- ☐ Spinocerebellar disease
- ☐ Stroke
- ☐ Other metabolic disorders
- ☐ Other neurodegenerative disorders
- ☐ None of these apply

2. Within the past two years, has a medical professional discussed any of the following treatment options that have not yet been addressed? Please check all that apply.

- ☐ Hospital admittance as an inpatient
- ☐ Organ transplant
- ☐ Back or spine surgery
- ☐ Joint replacement
- ☐ Surgery, radiation, or chemotherapy for cancer
- ☐ Heart surgery
- ☐ Vascular surgery
- ☐ None of these apply

3. Have you been diagnosed or treated (including taking medication) for any of the following conditions in the past five years? Please check all that apply.

Heart or vascular conditions
- ☐ Angina or heart attack
- ☐ Atrial fibrillation or flutter
- ☐ Coronary or carotid artery disease
- ☐ Congestive heart failure (CHF)

Lung or respiratory conditions
- ☐ COPD or emphysema
- ☐ Cancers or tumors
- ☐ Cancer (other than skin cancer)

Nervous system conditions
- ☐ Alzheimer's disease or dementia
- ☐ Multiple sclerosis
- ☐ Parkinson's disease

Diabetes
- ☐ With any of the following complications: circulatory problems, kidney problems or eye problems

Kidney conditions
- ☐ Chronic kidney disease

Liver conditions
- ☐ Cirrhosis

Immune system conditions
- ☐ Crohn's disease or ulcerative colitis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Other immune deficiency

Psychological conditions
- ☐ Bipolar or schizophrenia
- ☐ Major depression
- ☐ None of the conditions in question 3 apply

continued

4. Do you have any of the following chronic health conditions? Please check all that apply.

- ☐ Anxiety or mild depression
- ☐ Arthritis (hip or knee)
- ☐ Asthma
- ☐ Diabetes (with no complications)
- ☐ Enlarged prostate (BPH)
- ☐ Fibromyalgia
- ☐ GERD or acid reflux
- ☐ Glaucoma or macular degeneration
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism or hyperthyroidism
- ☐ Migraines
- ☐ Myasthenia gravis
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ None of these apply

Have you had any drugs administered in the doctor's office or hospital in the last 12 months? ☐ **Yes** ☐ **No**

List names of drugs if known:

_____

_____

_____

Please list prescriptions you have taken in the last 12 months for chronic conditions, some examples of chronic conditions are diabetes, high blood pressure or high cholesterol (please indicate N/A if you have no prescriptions to list):

_____

_____

_____

Additional Information

- You do not need more than one Medicare supplement plan.
- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If you are eligible for, and have enrolled in, a Medicare supplement plan 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 reinstituted if requested within 90 days after 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- To terminate your McLaren Medicare Supplement plan, please notify McLaren Health Plan in writing at least 30 days prior to termination. **Important! Do not terminate your McLaren Medicare Supplement until your new plan has accepted and confirmed your enrollment.**
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and Medicaid.

continued

7 Payment information

Choose one:

- ☐ Receive a monthly bill and pay by mail.
- ☐ On the due date for each bill, login to www.pay.instamed.com/mclaren.comm to securely pay your monthly premium by credit/debit card or by e-check.
- ☐ Electronic funds transfer from your bank account each month.

  On the due date for each bill, the checking or savings account you designate will be debited for the amount of your premium. Once enrolled, you can request a monthly statement by calling Customer Service at 888-327- 0671 (TTY:711).

If you have questions about the automatic bill payment plan, please contact Customer Service at 888-327- 0671 (TTY:711).

Name of financial institution	Account type ☐ Checking ☐ Savings
ABA/routing number or attach a copy of a voided check	Account number
Print name	

continued

8 Confirm your information

Please read, sign and date where indicated.

My signature indicates that I have read and understand the contents of this application. I declare that the answers on this application are complete and true to the best of my knowledge and belief, and are the basis for issuing coverage. I understand that the application and amendments become a part of the contract and that if the answers are incomplete, incorrect or untrue, McLaren Health Plan (MHP) may have the right to rescind my McLaren Medicare Supplement coverage or adjust my premium.

If I cancel within the first 30 days of the effective date of this coverage, I will be entitled to a refund of my previous premium payment. Please note that the reasonable costs for any health services paid by MHP during that time period will be deducted from the refund and I will be responsible for payment of reasonable fees for any health care services I received. If I choose to cancel my coverage after the first 30 days, I understand I must give at least 30-day advance notice in writing to MHP. I understand I cannot re-enroll with MHP for a period of six months and my enrollment may be subject to medical underwriting.

Any person who knowingly and with intent to defraud any health plan company or other person files an application or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any material fact, commits a fraudulent act when determined by a court of competent jurisdiction and may be subject to criminal and civil penalties. I understand

the coverage under the plan I am applying for will not take effect until issued by McLaren Health Plan. McLaren Health Plan requires proper handling of personal health information for its members. Details of McLaren Health Plan's confidentiality policies and procedures are available at:

McLarenHealthPlan.org/MedicareSupplement.

Please check one of the following:

☐ **Yes** ☐ **No** I have received a copy of the McLaren Medicare Supplement plan Outline of Coverage.

Applicant's printed name	Applicant's signature	Date

Authorization for protected health information use and disclosure

I understand that the following parties may need to collect information on me in regard to the proposed coverage: MHP and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose.

The following information may be disclosed to or by MHP: any and all individually identifiable health information, including but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results. The purpose of this authorization is at my request.

I specifically authorize MHP to disclose records related to mental health, substance abuse and HIV/AIDS.

The parties who may need to collect information may disclose information to the following: other insurers to which I have applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearing houses; or persons who perform business, professional, or insu ance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 30 months after the date it is signed.

continued

I understand that I can revoke this authorization at any time by giving written notice on a standard form avail- able online at McLarenHealthPlan.org/MedicareSupplement, or by contacting my agent. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization but if I do not provide it or revoke it, I may not be eligible for enrollment. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Applicant's printed name	
Applicant's signature	Date

If you are the authorized personal representative, you must provide the following information:

Personal representative's printed name			
Personal representative's signature		Date	
Street address	City	State	ZIP code
Phone	Relationship to applicant		

Applications can be submitted in the following ways:

Fax: 810-600-7931
Email: **MHPsales@mclaren.org**
Mail: McLaren Health Plan
G-3245 Beecher Road
Flint, Michigan 48532

****Important: All pages of the application must be submitted.****

continued

9 Agent use

Enrolling an individual in a Medicare supplement plan requires that you provide the following information.

1. Have you sold any other health plan policies to this individual that are still in force?

☐ **Yes**, policy descriptions (name of policy, policy number, start date):_____

_____

☐ **No**

2. Have you sold any health plan policies to this individual in the last five years that are not still in force?

☐ **Yes**, policy descriptions (name of policy, policy number, start date):_____

_____

☐ **No**

3. I asked the applicant all the questions in this application and the answers are recorded as given to me.

☐ **Yes**
☐ **No**

Managing agent / General agency name (if applicable)		
Email address	Primary phone	Fax
Agent's first and last name		
Agent's signature		Date agent accepted application
Name of person who entered application online		Relationship to applicant

Notice to applicant regarding replacement of Medicare supplement coverage or Medicare Advantage

McLaren MEDICARE SUPPLEMENT

McLaren Health Plan, G-3245 Beecher Road, Flint, Michigan 48532

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or the information you have furnished, you intend to drop or otherwise terminate existing Medicare supplement coverage or a Medicare Advantage plan and replace it with a new certificate to be issued by MHP. Your new certificate provides 30 days within which you may decide, without cost, whether you desire to keep the certificate.
You should review this new coverage carefully, comparing it with all disability and other health coverage you now have. You should terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by McLaren Medicare Supplement agent, broker or other representative:

I have reviewed your current medical or health coverage as disclosed to me. The replacement of coverage involved in this transaction does 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, to the best of my knowledge. The replacement plan is being purchased for the following reason (check one):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ Current plan has outpatient prescription drug coverage and I am enrolling in Part D.
☐ Disenrollment from a Medicare Advantage plan.
Reason for disenrollment: _____
☐ Other (please specify): _____
☐ Did not replace existing Medicare supplement coverage.

If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate 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.

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

The Notice to Applicant was delivered to me by my agent on (date): _____/_____/_____

Signature of agent, broker or other representative (signature not required for direct sale)		Date	
Printed name of agent		Agent NPN number	
Agent's street address	City	State	ZIP code
Applicant's signature		Date	
Printed name of applicant			
Policy, certificate or contract number being replaced			

Click Here to Submit Application

McLaren HEALTH PLAN | McLaren HEALTH ADVANTAGE | McLaren HEALTH PLAN COMMUNITY

McLaren MEDICARE SUPPLEMENT

Discrimination is against the law

McLaren Health Plan, MHP Community, McLaren Advantage (HMO) and McLaren Health Advantage (collectively McLaren) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. McLaren does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

McLaren:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free (no cost) language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact McLaren's Compliance Officer. If you believe that McLaren has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

- McLaren's Compliance Officer
  - Write: G-3245 Beecher Rd., Flint, MI 48532
  - Call: 866-866-2135, TTY: 711
  - Fax: 810-733-5788
  - Email: mhpcompliance@mclaren.org

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, McLaren's Compliance Officer is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue
SW Room 509F, HHH Building Washington, D.C. 20201
800-368-1019, 800-537-7697 (TTY)

Complaint forms are available at hhs.gov/ocr/office/file/index.html.

McLaren HEALTH PLAN

McLaren HEALTH ADVANTAGE

McLaren HEALTH PLAN COMMUNITY

McLaren MEDICARE SUPPLEMENT

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-327-0671 (TTY: 711).

Arabic:
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-888-327-0671 (رقم هاتف الصم والبكم: 711).

Syriac/Assyrian:
ܙܘܗܪܐ: ܐܢ ܐܢܬ ܗܘ ܡܣܘܚܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܒܐܬܝܐ ܠܘܟ ܬܫܡܫܝܬܐ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-888-327-0671 (TTY: 711)

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-327-0671（TTY：711）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-327-0671 (TTY: 711).

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-888-327-0671 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-888-327-0671 (TTY: 711)번으로 전화해 주십시오.

Bengali: লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-888-327-0671 (TTY: 711)।

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-888-327-0671 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-327-0671 (TTY: 711).

Italian: ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-888-327-0671 (TTY: 711).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-888-327-0671（TTY:711）まで、お電話にてご連絡ください。

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-327-0671 (телетайп: 711).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-327-0671 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-888-327-0671 (TTY: 711).

McLaren MEDICARE

SUPPLEMENT

McLarenHealthPlan.org/MedicareSupplement

MHPS201700821 Rev. 01/2025