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 ☐ McLaren Health Plan Community ☐ 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. Applicants who have any of these benefits 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

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
☐ McLaren Health Plan Community
☐ 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. Applicants who have any of these benefits 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

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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 below for last year. Then fill in the requested information.

☐ 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 33:

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

Total Household Resources from Line 34:

☐ I want to report my income a different way:

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

QUESTIONS?

Call us at **1-866-824-9772**
(TTY: 1-866-824-7002)
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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 tax return for last year, 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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