Acknowledgement of Receipt of Medicare SELECT Disclosure Statement

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

Member Services Department
1-800-752-5863

I, the applicant, acknowledge receipt of the following information:

- ☐ Outline of Coverage and Premium Information for the Medicare SELECT Plan for which I am applying;
- ☐ Description of Network hospitals and outpatient surgery center; and
- ☐ This Medicare SELECT Disclosure Statement.

I also understand the following:

- ☐ Facility expenses will be denied if you receive inpatient hospitalization services or outpatient surgery service in a non-network facility (except as provided in the Medicare SELECT provider restrictions).
- ☐ Sanford Health Plan does not advise the purchase of a Medicare SELECT policy if I do not live within a reasonable distance of the network hospital.
- ☐ My physician must have admitting privileges at network hospital; or should be willing to refer me to a physician who does in the event I require hospitalization.
- ☐ I have the right to purchase any non-restricted medicare supplement insurance product offered by Sanford Health Plan.

I acknowledge receipt and understanding of the information above.

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Applicant Signature **Date**

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Applicant Name

White: Plan Copy; Canary: Applicants Copy; Pink: Agent Copy