

Application for Medicare Supplement Insurance Plan



BlueCross BlueShield of Texas

Instructions

Complete this application in ink and sign on the appropriate line in PART THREE. To be considered for coverage, you must be age 65 or over, reside in Texas and have Medicare Parts A and B.

Send no money now! No payment is due until you review your coverage.

PART ONE

SECTION A. Plan Selection

I would like to apply for Medicare Supplement: *(check only one box)*

Plan A Plan D Plan F Plan K Plan L

Make policy effective:
MONTH DAY YEAR

PAYMENT OPTION *(Reminder: SEND NO MONEY NOW)*

I prefer to be billed: *(Please select one)*

Monthly Every two months Every three months Every six months Every twelve months

I understand I may apply to pay my premium by monthly bank draft after I make my first premium payment.

SECTION B.

Personal Information

Name
LAST

FIRST M.I.

Address 1

Address 2

City

County

State ZIP

Male Female

Your Birthdate
MONTH DAY YEAR

Height ft. in. Weight lbs.

Your Social Security No.

SECTION C.

Medicare Claim Number and Effective Date

Please see your Medicare card for this information.

Copy the Medicare Claim Number and Part A and B effective dates from your red, white and blue Medicare card. This information must be provided for us to complete your application process.

Your Medicare Claim No.

- -

(please include any prefixes or suffixes)

Your Medicare Part A effective date

MONTH DAY YEAR

Your Medicare Part B effective date

MONTH DAY YEAR

PART ONE Continued Inside ►►►

SECTION D. Consumer Protection Information

Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.

- 1. Do you have another Medicare Supplement policy in force?
a. If yes, with what company, and what plan do you have?
b. If yes, do you intend to replace your current Medicare Supplement policy with this policy?
2. Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy?
a. If yes, which company provides the health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy?
b. If yes, what type of policy is it?
3. Do you have or have you had a Blue Cross and Blue Shield of Texas health insurance policy?
If yes, what type of policy?
4. Are you covered for medical assistance through the state Medicaid program?
{NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.}
a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy?
b. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?

SECTION E. Guaranteed Issue Eligibility

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please answer all questions. Please mark Yes or No with an "X" to the best of your knowledge.

- 1. Did you turn age 65 in the last 6 months?
2. Did you enroll in Medicare Part B in the last 6 months?
If yes, what is the effective date? MONTH DAY YEAR

(Continued on next page)

PART TWO

HEALTH HISTORY/MEDICAL QUESTIONS

Please answer the following health history questions. **Note: Anyone in Open Enrollment or if you have determined that you are eligible for Guaranteed Issue based on SECTION E, "Guaranteed Issue Eligibility," you are not required to answer the following health questions. Please continue to PART THREE.**

1. When you first became eligible for Medicare, was it either because of disability or end stage renal disease? Yes No

2. Within the past **5 years**, have you been diagnosed, treated, hospitalized or recommended for treatment, including drug therapy, by a physician or any other provider for any of the following:

	Yes	No		Yes	No
a. Diabetes with amputation, loss of sight or complications affecting the kidney?	<input type="checkbox"/>	<input type="checkbox"/>	i. Congestive heart failure or heart valve replacement?	<input type="checkbox"/>	<input type="checkbox"/>
b. Organ or tissue transplant (except cornea)?	<input type="checkbox"/>	<input type="checkbox"/>	j. Nephritis or kidney failure?	<input type="checkbox"/>	<input type="checkbox"/>
c. Cancer (excluding basal cell or squamous cell cancer of the skin)?	<input type="checkbox"/>	<input type="checkbox"/>	k. Cirrhosis of the liver or Hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>
d. Leukemia or Hodgkin's disease?	<input type="checkbox"/>	<input type="checkbox"/>	l. Multiple Sclerosis or neuromuscular disorders?	<input type="checkbox"/>	<input type="checkbox"/>
e. Stroke, Transient Ischemic Attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>	m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)?	<input type="checkbox"/>	<input type="checkbox"/>
f. Alzheimer's disease, senility, dementia or brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>	n. Respiratory or lung disease requiring use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
g. Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	o. Alcohol or chemical dependency?	<input type="checkbox"/>	<input type="checkbox"/>
h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty?	<input type="checkbox"/>	<input type="checkbox"/>			

3. Within the past **5 years**, have you been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes No

4. Within the past **2 years**, have you been advised to have kidney dialysis, joint replacement, or surgery for the heart, arteries or intestines that has not yet been done? Yes No

5. Within the past **2 years**, have you been hospitalized 2 or more times, or have you been confined to a nursing home for 14 or more days? Yes No

6. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair or a home health care agency? Yes No

7. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty?
 - Taking Medications • Eating • Walking • Moving from place to place in your home
 - Getting in and out of bed or chairs • Bathing • Dressing • Toileting Yes No

(Continued on next page)

PART THREE - REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I have read and understand the statements below regarding Medicare Supplement coverage from Blue Cross and Blue Shield of Texas, which is herein called the Company. I have received an Outline of Coverage for the policy I applied for, and a Medicare Supplement Buyers Guide.

Medical Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Important Information Regarding Medicare Supplement Coverage:

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, 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 policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility.* If you are eligible for, and have enrolled in a Medicare Supplement policy 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 reinstated if requested within 90 days of 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

PART THREE Continued on next page ►►

PART THREE Continued

Important Information Regarding Medicare Supplement Coverage:

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

I hereby apply for coverage and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.

I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested. If I falsify or fail to include all material information (e.g. age and medical history) required on this application, my policy will be rescinded by the Company. Rescission means voiding my policy back to its effective date. If my policy is rescinded, any premiums paid (less any benefits paid) will be refunded.

I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.

The undersigned acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an Individual Policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy. The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by the Company in connection with the issuance of the Individual Policy, he/she should contact the agent.

SIGNATURE *Must be signed and dated to avoid delays in processing.*

Please sign here in ink: X _____ Date Signed: _____ / _____ / _____
SIGNATURE OF APPLICANT MONTH DAY YEAR

Please print your name here: _____ Phone Number: (____) _____
NAME OF APPLICANT AREA CODE

AGENT INFORMATION — Note to Agent: List the following:

Any other health insurance policies or coverages sold to the applicant which are still in force:

Any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

I have reaffirmed that the information supplied on this application is accurate and complete.

Signature: X _____ Date Signed: _____ / _____ / _____ Phone Number: (____) _____
MONTH DAY YEAR AREA CODE

Print name: _____ Agent Code: _____ Firm Name: _____
(Social Security Number or Tax ID Number) (If Applicable)