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: *(check only one box)*

☐ **Plan A Medicare Supplement**   ☐ **Plan D Medicare Supplement**   ☐ **Plan F Medicare Supplement**

Make policy effective: ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

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

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

☐ Monthly ☐ 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

☐☐ 0 1 ☐☐☐☐
MONTH DAY YEAR

Your Medicare Part B effective date

☐☐ 0 1 ☐☐☐☐
MONTH DAY YEAR

PART ONE Continued Inside ▸▸▸

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SECTION D. *Consumer Protection Information*

Please answer all questions to the best of your knowledge.

1. Do you have any other Medicare Supplement insurance policy or certificate in force? . . . . . ☐ Yes ☐ No

a. If **yes**, with which company? ______

b. If **yes**, do you intend to replace your current Medicare Supplement policy with this policy? . . . . . ☐ Yes ☐ No

*If **yes**, you must complete the replacement form.*

2. Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? . . . . . ☐ Yes ☐ No

If **yes**: **a.** Which company provides the health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? ______

b. 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? ☐ Yes ☐ No

If **yes**: What type of policy? ______

4. *Medicaid* is a public aid program for people with low income. It is not the same as Medicare. Are you covered by *Medicaid*? . . . . . ☐ Yes ☐ No

If **yes**, do you qualify for: **a.** ☐ Specified Low Income Medicare Beneficiary assistance (SLMB)

b. ☐ Qualified Medicare Beneficiary assistance (QMB), or

c. ☐ Other *Medicaid* medical benefits?

SECTION E. *Guaranteed Issue Eligibility*

Please read the following information carefully to determine if you are eligible for coverage on a Guaranteed Issue basis. If you can answer "yes" to any of the questions listed below, you do not have to complete PART TWO of the application (health history/medical questions). Your acceptance is guaranteed.

Are you applying for coverage within six months before or after the first day of the month in which you enrolled in Medicare Part B? . . . . . ☐ Yes ☐ No

Have any of the following events occurred? If so, and if you are applying before the 63rd day after your coverage terminated, you are an Eligible Person for Guaranteed Issue: . . . . . ☐ Yes ☐ No

Please attach supporting documentation if you've answered yes to any of these questions.

- Were you enrolled in an employer/retiree group health coverage and canceled because you either could no longer be covered under the terms of the plan or the company is canceling the company plan in its entirety?
- Were you enrolled in a Medicare+Choice (including Medicare HMO) plan, a Medicare Select plan or a PACE program and were disenrolled because you moved out of the service area?
- Were you enrolled in a Medicare+Choice (including Medicare HMO) plan or PACE program and were disenrolled because your plan withdrew from your service area?
- Were you enrolled in a Medicare+Choice (including Medicare HMO) plan for the first time since you became Medicare Eligible and were disenrolled or you decided to disenroll within one year of initial enrollment?
- Did you have a Blue Cross and Blue Shield of Texas Medicare Supplement plan and then you canceled it to enroll in a Medicare+Choice (including Medicare HMO) plan, a Medicare Select plan or a PACE program within the last 12 months, and then you disenrolled from your new plan within one year of initial enrollment?
- Were you enrolled in a Medicare Supplement plan and your previous carrier ended your coverage through no fault of your own?

PART TWO

HEALTH HISTORY/MEDICAL QUESTIONS

Please answer the following health history questions.

Note: If you answered "Yes" to any of the questions in SECTION E, "Guaranteed Issue Eligibility" on the previous page, you do not have to complete this section. 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:

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

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 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

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. 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. Counseling services are 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 my Blue Cross and Blue Shield of Texas 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 Blue Cross and Blue Shield of Texas has the right to reject my application. If Blue Cross and Blue Shield of Texas rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.

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)