



An Independent Licensee of the Blue Cross and Blue Shield Association,
an association of independent Blue Cross and Blue Shield Plans.

Application for Senior Medicare Supplement Plans

**BLUE CROSS AND BLUE SHIELD OF MONTANA
P.O. BOX 4309
HELENA, MT 59604**

- New Enrollment
- Change Benefit Plan (e.g., Plan F to Plan C)
- Transfer (Current ID number) from other carrier or state

Application For Senior Medicare Supplement Plans

❖❖ If you are not enrolled in Medicare Part A and B, you are not eligible for these plans. ❖❖					
Plan Selection	Requested Effective Date (subject to BCBSMT approval; specify 1st or 15th of month) _____ (mo day yr)	Senior Plan/Entry Age Complete entire Medical History section if applying after your Medicare B open enrollment period has ended. <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan C <input type="checkbox"/> Other _____	Senior Blue/Attained Age Complete entire Medical History section if applying after your Medicare B open enrollment period has ended. <input type="checkbox"/> Plan A <input type="checkbox"/> Plan F <input type="checkbox"/> Plan B <input type="checkbox"/> Plan G <input type="checkbox"/> Plan C <input type="checkbox"/> Other _____		
	Last Name _____		First Name _____		MI _____
General Information	Daytime Phone _____		Date of Birth (mo day yr) _____	Male/ Female _____	Height _____
	Applicant/Subscriber Mailing Address _____		City _____	State _____	ZIP Code _____
	Applicant/Subscriber Billing Address (if different from above) _____		City _____	State _____	ZIP Code _____
	Medicare Number (Reference your Medicare card and include letters preceding or following the number.) _____		Enrolled in Medicare Part A Effective Date (mo day yr) _____		Enrolled in Medicare Part B Effective Date (mo day yr) _____
Employer Contribution	<p>1. Are you currently employed by a firm, which, for at least 50 percent of its working days during the preceding calendar year, employed two or more employees? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Will all or part of your premium be paid by your employer? <input type="checkbox"/> Yes* <input type="checkbox"/> No *If yes, you may not be eligible for this coverage through Blue Cross and Blue Shield of Montana (BCBSMT).</p>				
Other Coverage Options	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 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 on the following page.				
Office Use Only	Age Over _____	<input type="checkbox"/> Approved _____		Date Stamps	
	Group Number _____	Effective Date _____			
	Package Number _____	<input type="checkbox"/> Declined _____			
	Medical Notes 7 8 10 11 13	Decision Date _____			
	Effective Date _____				

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? Yes No
2. Did you enroll in Medicare Part B in the last 6 months? Yes No
If yes, what is the effective date? _____
3. Did you enroll in Medicare Part C in the last 12 months? Yes No
If yes, what is the effective date? _____
4. Did you enroll in Medicare Part D in the last 6 months? Yes No
If yes, what is the effective date? _____
5. Are you covered for medical assistance through the state Medicaid program? Yes No
(Note to Applicant/Subscriber: If you are participating in a "spend-down" program and have not met your "share of cost," please answer No to this question.)
 - b. If yes, will Medicaid pay your premiums for this Medicare supplement policy? Yes No
 - c. If yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?
 Yes No
 - d. Are you applying to reinstate a suspended Medicare supplement plan? Yes No

6. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g., a Medicare Advantage plan, a Medicare HMO or PPO)? Yes No
 - a. If yes, with what company and what kind of coverage?

Company Name	Company Telephone	Subscriber ID	Type of Coverage
b. What are your dates of coverage under this plan? If you are still covered under this plan, leave "End" blank.			
Start <small>(mo day yr)</small>		End <small>(mo day yr)</small>	

- c. Reason you are ending or ended your Medicare plan. _____
- d. Was this your first time in this type of Medicare Plan? Yes No
- e. Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- f. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement plan? Yes No

7. Have you had another Medicare supplement plan in force within the last 63 days? Yes No
 - a. If yes, with what company, and what plan do you have?

Company Name	Company Telephone	Subscriber ID	Plan Name/Type
b. What are your dates of coverage under this plan? If you are still covered under this plan, leave "End" blank.			
Start <small>(mo day yr)</small>		End <small>(mo day yr)</small>	

- c. If you are still covered under the Medicare supplement plan, do you intend to replace your current plan with this new Medicare supplement plan? Yes No
- d. Reason you are ending or ended your Medicare supplement plan. _____

8. Have you had coverage under any other health insurance (e.g., an employer, union, or individual plan) within the past 63 days? Yes No
 - a. If yes, with what company and what kind of policy (e.g., employer, union, individual)?

Company Name	Company Telephone	Subscriber ID	Type of Coverage
b. What are your dates of coverage under this other plan? If you are still covered under this plan, leave "End" blank.			
Start <small>(mo day yr)</small>		End <small>(mo day yr)</small>	

- c. Reason you are ending your health coverage. _____

Open enrollment begins on the first day of the month in which you are 65 or older and are enrolled for benefits under Medicare Part B and continues for six months after that date. If applying for any Senior Plan or Senior Blue Plan, after your open enrollment period has ended, complete the entire Medical History section.

Other Coverage Options

If additional space is necessary to give complete information, use a separate sheet of paper, signed and dated.

Medical History	A. Within the last three (3) years, have medications (except antibiotics) been recommended or prescribed for, or been provided to (e.g., samples, injections), and/or been taken by you? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain below.				
	Name of Medication, Daily Dosage, and How Often Refilled	Condition for Which Medication Was Prescribed or Taken	Dates From To <small>(mo day yr) (mo day yr)</small>		Complete Provider Name (First and Last) Address City State ZIP Code

B. Have you been diagnosed with, or treated or counseled for, any complaint, condition, illness, disorder, or disease relating to any of the following in the past five (5) years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain below.				
1. <input type="checkbox"/> Cancer	5. <input type="checkbox"/> Diabetes	9. <input type="checkbox"/> Arthritis	12. <input type="checkbox"/> Osteoporosis	
2. <input type="checkbox"/> Heart Problems	6. <input type="checkbox"/> Renal Failure	10. <input type="checkbox"/> Parkinson's	13. <input type="checkbox"/> Joints	
3. <input type="checkbox"/> Lungs	7. <input type="checkbox"/> Back	11. <input type="checkbox"/> Alzheimer's	14. <input type="checkbox"/> Fractures	
4. <input type="checkbox"/> Cataracts	8. <input type="checkbox"/> Stroke or Circulatory Problems			
Condition Number (1-14)	Diagnosis/Condition	Dates From To <small>(mo day yr) (mo day yr)</small>		Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Have you received or been recommended to receive any medical treatment that has not been listed above? This includes counseling, follow-up for abnormal laboratory results, examinations/tests, or care recommended by physicians, other medical practitioners, or a legal authority. <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please indicate whether the treatment has been received or recommended, and provide date(s) and detailed explanation(s).	
D. Have you been hospitalized or confined to a nursing facility within the past two (2) years? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide date(s) and detailed explanation(s).	
E. Are you bedridden or confined to a wheelchair; or during the past two (2) years, have you had any type of amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide date(s) and detailed explanation(s).	

Notice	<p>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 whether you need multiple coverages. 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 must 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. Upon receipt of timely notice, the issuer must either return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility or provide coverage to the end of the term for which premiums were paid, at the option of the insured, subject to adjustment for paid claims. 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 the Medicare supplement policy provided coverage for outpatient prescription drugs</p>
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Applicant/Subscriber Name:

Billing Frequency

Check the appropriate box below for the desired billing frequency. If no option is selected, Blue Cross and Blue Shield of Montana will bill monthly.

Monthly Quarterly Semiannually Annually

Electronic Funds Transfer (EFT) Authorization

This section must be completed in full, and a voided check or savings account deposit slip must be attached for electronic funds transfer (EFT) billing to be applied. If any information is missing, you will be billed directly.

Authorization Agreement for EFT Payment Method
Please complete the following only if you would like your premium deducted from your checking or savings account.

To: _____
(Bank Name, City, and State)

I hereby authorize Blue Cross and Blue Shield of Montana (BCBSMT) to initiate funds transfers for the health insurance premiums due and owing for the above named Policy from the designated Bank Account and authorize the above named Financial Institution to honor these transfers. I understand that this Agreement and Authorization will remain in effect until BCBSMT has received written notice from me (or, if a group policy, any individual authorized to act on behalf of the employer) that it should be cancelled. Any such written notice must be given not less than **ten** days before the next scheduled payment. I also understand that this Agreement and Authorization does not affect BCBSMT's right to cancel the Policy for nonpayment (if there are insufficient or no funds in the designated Bank Account) as authorized by and in accordance with the Policy and applicable law. I agree to indemnify and hold harmless BCBSMT for any claims or losses arising out of any transfers or deductions from the designated Bank Account pursuant to this Agreement and Authorization.

If signing on behalf of or for a group, the individual(s) signing below warrant that they are duly authorized to execute this Agreement and Authorization on behalf of the employer and that such execution is binding upon said employer without further action or ratification.

Account Owner's Name (Print):	Type of Account:
_____	<input type="checkbox"/> Checking <input type="checkbox"/> Savings

Account Owner's Signature, Required (Do Not Print):	Account Number	_____
_____	Routing Number	_____

Blue Cross and Blue Shield of Montana agrees to pay to any bank or banker all sums of money that said bank or banker shall become legally obligated to pay because of any deduction of money for Blue Cross and Blue Shield of Montana as herein authorized by the bank customer whose signature appears above.

NAME OF DEPOSITOR _____ 101
STREET ADDRESS _____
CITY, STATE, AND ZIP CODE _____ 20 _____

Please attach voided check or savings account deposit slip.

PAY TO THE ORDER OF _____

NAME OF YOUR BANK _____

FOR _____

021001082 1234567 0101

ROUTING NUMBER ACCOUNT NUMBER

❖❖ You do not need more than one Medicare supplement policy. ❖❖