Application for Senior Medicare Supplement Plans

BLUE CROSS AND BLUE SHIELD OF MONTANA

P.O. BOX 4309
HELENA, MT 59604

Applicant/Subscriber Name:

- ❑ 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

Plan Selection

❖❖ If you are not enrolled in Medicare Part A and B, you are not eligible for these plans. ❖❖

Requested Effective Date (subject to BCBSMT approval; specify 1st or 15th of month)	Simply Blue/Entry Age	Simply Blue/Attained Age
______________ (mo | day | yr)	Complete entire Medical History section if applying after your Medicare B open enrollment period has ended. ❑ Plan A ❑ High Deductible F ❑ Plan C ❑ Plan M ❑ Plan F ❑ Plan N ❑ Other __________	Complete entire Medical History section if applying after your Medicare B open enrollment period has ended. ❑ Plan A ❑ High Deductible F ❑ Plan C ❑ Plan M ❑ Plan F ❑ Plan N ❑ Other __________

General Information

Last Name	First Name	MI	Social Security Number (SSN)

Daytime Phone	Date of Birth (mo | day | yr)	Male/ Female	Height	Weight

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

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?** ❑ Yes ❑ No
2. **Will all or part of your premium be paid by your employer?** ❑ Yes* ❑ No

***If yes, you may not be eligible for this coverage through Blue Cross and Blue Shield of Montana (BCBSMT).**

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	❑ Approved __________	Date Stamps
Group Number		
Package Number	Effective Date __________	
Medical Notes 7 8 10 11 13	❑ Declined __________	
Effective Date	Decision Date __________	

Applicant/Subscriber Name:

Other Coverage Options

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 (mo | day | yr	**End** (mo | day | yr)

   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 (mo | day | yr)	**End** (mo | day | yr)

   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 (mo | day | yr)	**End** (mo | day | yr)

   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 Simply Blue/Entry Age or Simply Blue/Attained Age, after your open enrollment period has ended, complete the entire Medical History section.

Applicant/Subscriber Name:

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

Please do not provide any information regarding any genetic tests you or any family member have had, the results of such tests, or any family medical history (other than medical history requested in this application) that may indicate genetic predisposition to any disease or disorder.

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? ❑ Yes ❑ 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 (mo | day | yr)	Dates To (mo | day | yr)	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? ❑ Yes ❑ No If yes, please explain below.

1. ❑ Cancer
2. ❑ Heart Problems
3. ❑ Lungs
4. ❑ Cataracts
5. ❑ Diabetes
6. ❑ Renal Failure
7. ❑ Back
8. ❑ Stroke or Circulatory Problems
9. ❑ Arthritis
10. ❑ Parkinson's
11. ❑ Alzheimer's
12. ❑ Osteoporosis
13. ❑ Joints
14. ❑ Fractures

Condition Number (1-14)	Diagnosis/Condition	Dates From (mo | day | yr)	Dates To (mo | day | yr)	Hospitalized	Complete **Provider Name** (First and Last) or **Facility Name** **Address** City State ZIP Code
				❑ Yes ❑ No	
				❑ Yes ❑ No	
				❑ Yes ❑ 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.
❑ Yes ❑ 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?
❑ Yes ❑ 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? ❑ Yes ❑ No If yes, please provide date(s) and detailed explanation(s).

Notice

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

Applicant/Subscriber Name:

Notice

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. 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 prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of suspension. 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).

Conditions of Enrollment

I, the undersigned, do hereby make application for membership in Blue Cross and Blue Shield of Montana. I hereby agree to the Articles of Incorporation and Bylaws and to the terms and conditions of any Membership Contract and Medical-Surgical and/or Hospital Agreement issued to me by Blue Cross and Blue Shield of Montana.

I agree that any provider of medical service to anyone whose name appears on this application or the Centers for Medicare and Medicaid Services (CMS) is authorized upon request to furnish information and reports regarding such services to Blue Cross and Blue Shield of Montana.

I have received the Notice of Privacy Practices.

I hereby agree to pay the prevailing dues for membership for which application is made, starting with the effective date.

The responses and information I have provided in this application are complete, accurate and current. I understand that, even if BCBSMT has accepted any dues or premium payments, BCBSMT may decline to issue coverage or may cancel any coverage issued from its beginning based upon any misrepresentation, omission, concealment of facts, or incorrect statement: (a) that is fraudulent; (b) that is material to the acceptance of the risk assumed by BCBSMT; or (c) with respect to which, had the true facts been made known to BCBSMT, BCBSMT would not have issued any policy, would not have issued the particular policy, would have issued a policy only with one or more elimination riders, or would have issued a policy with a different dues or premium amount.

Applicant Signature

I have received a copy of (mark all that apply):

❑ **Buyer's Guide** ❑ **Replacement Notice** ❑ **Outline of Coverage**

I understand and agree that the coverage I am applying for is subject to eligibility requirements and the effective date will be assigned by Blue Cross and Blue Shield of Montana. I have read the Conditions of Enrollment. I understand and agree to them.

Signature DO NOT PRINT	**Signature Date** (mo | day | yr)

To Be Completed by Your Sales Representative

Representative: List any other health insurance policies you have sold to the applicant, including policies which are still in force and policies sold in the past five (5) years which are no longer in force.

Representative Signature		**Signature Date** (mo | day | yr)
Representative Name	**Representative Number**	**Telephone Number**

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

POLICY INFORMATION

Type of Election: ☐ New EFT Enrollment ☐ Change Bank Information ☐ Discontinue EFT Service

Complete this page if you wish to have your health insurance premiums deducted electronically from your bank.

Banking Information

Financial Institution Name	City	State

Bank Routing (ABA)	Bank Account Number

Account funds are to be transferred from (please select only one): ☐ Checking ☐ Savings

Authorization, Conditions, and Signature

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 my designated Bank Account and hereby authorize my 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 that it should be canceled, and that any such written notice must be given by me 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 my Policy for nonpayment (if there are insufficient or no funds in my designated Bank Account) as authorized by and in accordance with my Policy and applicable law.

I understand and agree that it is my responsibility to ensure that the information provided on this form is complete and accurate, and to provide prompt notice to BCBSMT of any changes. I agree to indemnify and hold harmless BCBSMT for any claims or losses arising out of any transfers or deductions from my Bank Account pursuant to this Agreement and Authorization

Account Owner's Name (Print):

Please sign and date below.

Account Owner Signature Date

PLEASE RETURN A VOIDED CHECK WITH THIS FORM

NAME OF DEPOSITOR
STREET ADDRESS
CITY, STATE, ZIP CODE

101

20

Please attach copy of voided check.

PAY TO THE
ORDER OF:

NAME OF YOUR BANK

021001082 1234567 0101

Routing Number Account Number

PLEASE MAIL COMPLETED FORM AND VOIDED CHECK TO:

Blue Cross and Blue Shield of Montana, P.O. Box 4309, Helena, MT 59604

If you have questions, please call 1-800-447-7828

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

Applicant/Subscriber Name:

Application Checklist

Have you …

- ☐ Answered all the questions and “yes” responses and included start and/or end dates?
- ☐ Completed the Medical History if you are not applying during open enrollment or other qualifying event?
- ☐ Signed and dated the application?
- ☐ Completed the billing page and, if EFT is requested, enclosed a voided check or savings account deposit slip for the account to be charged?