FOR OFFICE USE ONLY

Accept. Code_____

Plan Type_____

Market Code_____

Application for Blue Shield of California Medicare Supplement Plans

Blue Shield of California

An Independent Member of the Blue Shield Association

HERE'S HOW TO APPLY

1. Provide ALL requested information and print clearly in ink.
2. Sign and date in all places indicated.
3. Within 30 days of your signature date, mail the application in the enclosed postage-paid envelope. Keep the yellow copy for your records.
4. Please submit your first payment along with your application. Blue Shield will refund your payment if your application is not approved.

If you have questions about how to enroll, please call us at **(800) 248-2341** [TDD: (800) 241-1823].

You and your spouse or domestic partner may qualify for a TWO-PARTY CONTRACT. Both individuals must be age 65 or older, enrolled in both Medicare Parts A and B, and apply for the same plan type. Either person who does not qualify for guaranteed acceptance (see below) will be subject to underwriting.

1. If you and your spouse/domestic partner are applying for a two-party contract, please check this box: ☐
2. Is your spouse/domestic partner currently enrolled in a Blue Shield Medicare Supplement plan? ☐ YES ☐ NO
   A. If YES, which Plan Type? _____ Please provide your spouse/domestic partner's name and Social Security number below.
   B. If NO, and you are both currently applying for coverage, you and your spouse/domestic partner must each complete your own application. On each application, please provide your spouse/domestic partner's name and Social Security number.

Name of Spouse/Domestic Partner: _____

Spouse/Domestic Partner's Social Security Number: _____

Please enclose only one check for the applicable two-party rate, which can be found on the enclosed rate sheet.

☐ Check enclosed with this application

☐ Check enclosed with spouse/domestic partner's application

PERSONAL INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Home Address _____

City _____ State _____ Zip _____

Billing Address (if different from above) _____

City _____ State _____ Zip _____

Home Telephone (_____) _____ E-mail _____ Sex ☐ Male ☐ Female

Date of Birth ☐☐ (MONTH) - ☐☐ (DAY) - ☐☐☐☐ (YEAR) Language Preference ☐ English ☐ Spanish ☐ Chinese ☐ Other_____

Please check the Plan Type you are applying for: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ H ☐ I

Requested Effective Date _____ (MONTH) 1, 20_____ (YEAR) ***OR*** _____ (MONTH) 15, 20_____ (YEAR)

Medicare Number _____ Social Security Number _____

I'm entitled to: Hospital (Part A) Effective Date _____ Medical (Part B) Effective Date _____

GUARANTEED ACCEPTANCE

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the box below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

I believe I qualify for guaranteed acceptance based on situation number ☐.

STATEMENT OF HEALTH

If you qualify for enrollment on the basis of guaranteed acceptance, you will not be denied coverage based on your answers below. Please answer "Yes" or "No" to each question.

1. Have you, **within the past three years,** received treatment or been hospitalized for any of the conditions listed below? If "Yes," please explain the condition and indicate date of treatment at the end of this section.
   - ☐ Yes ☐ No Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
   - ☐ Yes ☐ No Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
   - ☐ Yes ☐ No Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
   - ☐ Yes ☐ No Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.
   - ☐ Yes ☐ No Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
   - ☐ Yes ☐ No Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*
   - ☐ Yes ☐ No Cancer or malignant tumors.
   - ☐ Yes ☐ No Have you received treatment or been hospitalized for any other condition than those listed above?
2. ☐ Yes ☐ No Do you have a pacemaker or artificial heart valve or have you had transplant surgery or heart surgery such as angioplasty or bypass? If "Yes," please explain the condition and indicate date of treatment at the end of this section.
3. ☐ Yes ☐ No Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital or other institution within the past three years? If "Yes," please explain the confinement and indicate date of confinement at the end of this section.
4. ☐ Yes ☐ No Are you currently taking medication? If "Yes," please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.

If you answered "Yes" to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary and sign and date each sheet.

Condition or Medication	**Date**	**Explanation/Current Status**

*California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

CURRENT HEALTH PLAN INFORMATION

To the best of your knowledge:

1A. ☐ Yes ☐ No Do you have a Blue Shield of California Medicare Supplement plan and want to transfer to a different Blue Shield Medicare Supplement plan?

1B. ☐ Yes ☐ No Do you have a Medicare Supplement plan policy or contract from a company other than Blue Shield of California?

If yes, with which company? _____

If yes, do you intend to replace your current policy or contract with a Blue Shield Medicare Supplement plan? (Please complete and return the Replacement of Medicare Supplement Coverage form in this packet.)

2. ☐ Yes ☐ No Do you have any other health coverage that provides benefits similar to this Blue Shield Medicare Supplement plan?
   (a) If yes, with which company? _____
   (b) What kind of coverage? _____
3. Are you covered for medical assistance by Medi-Cal:
   ☐ Yes ☐ No (a) As a specified low-income Medicare beneficiary (SLMB)?
   ☐ Yes ☐ No (b) As a qualified Medicare beneficiary (QMB)?
   ☐ Yes ☐ No (c) For other Medi-Cal or Medicaid medical benefits?
4. ☐ Yes ☐ No Did you have Medicare coverage before age 65?
   (a) If yes, why? _____
   (b) What is the current status? _____

BILLING INFORMATION

Please include your first payment along with your application. To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement Plans Summary of Benefits and Provisions. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, Health Service Agreement and member identification card as proof of approval.

Select your payment choice: ☐ Easy$Pay℠ (automatic monthly debit – you must complete the enclosed form)
☐ Quarterly billing ☐ Monthly billing

TERMS, CONDITIONS AND AUTHORIZATIONS

Information Regarding Medicare Supplement Coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.

1. You do not need more than one Medicare Supplement plan policy or contract.
2. If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3. You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare Supplement contract.
4. The benefits and dues under your Blue Shield Medicare Supplement plan can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your plan will be reinstated, if requested, within 90 days of losing Medi-Cal eligibility.
5. Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

Conditions of Membership:

1. This application and the Statement of Health, together with the *Evidence of Coverage and Health Services Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2. I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3. Only Blue Shield can approve this application. I understand that any insurance agent, broker or sales representative cannot grant approval, change terms or waive requirements.
4. By signing this form you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.
   Further, by signing this form you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits.
   You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations upon receipt of this signed authorization.
   You are entitled to a copy of this Authorization after you sign it.

TERMS, CONDITIONS AND AUTHORIZATIONS, *continued*

Expiration: This authorization will remain valid 1) for thirty (30) months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

5. I acknowledge receipt of the Summary of Benefits, the "Guide to Health Insurance for People with Medicare" and a copy of this application. I have read the Summary of Benefits and the terms, conditions and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

SIGNATURE

_____

Applicant's Signature Date

PRODUCER INFORMATION

Agent/Broker Name_____ Oleg Skurskiy_____

Agent/Broker ID _____ XXXXX0570_____ Agent/Broker Phone # 818-987-5000_____

Please list any other health insurance policies or plan contracts they have sold to the applicant as follows:

List policies and plan contracts sold that are still in force _____

List policies and plan contracts sold in the past five (5) years that are no longer in force: _____

You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

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White copy: Give to your Blue Shield Agent or mail to Blue Shield's Underwriting Department with your first payment.
Yellow copy: Keep with your important Blue Shield documents and information.