



SENIOR ENROLLMENT APPLICATION

For Seniors with Medicare Parts A and B Please complete entire application.

Application for a Medicare SELECT Plan or Standard Plan A to supplement Medicare (Select one)

- Blue Cross Senior ClassicSM C
- Blue Cross Senior Classic F
- Blue Cross Senior Classic I
- Blue Cross Senior Classic J
- Standard Plan A

A two-party contract (Member and Spouse rate) is available for eligible couples, at their option. Both spouses must be age 65 or older, enrolled in both Parts A and B of Medicare, and apply for the same plan.

If you and your spouse are applying for a two-party contract, please check this box: Yes No

If yes, you and your spouse will each have to fill out your own application, list the other spouse's name and Social Security Number, and submit both applications together.

Name of Your Spouse _____

Your Spouse's Social Security Number _____

Please enclose only one check for the applicable rate for the two of you.

Section 1 – Applicant Information

This complete original application will be returned to you, for your records, along with your certificate, when you are enrolled.

Please copy the information from your Medicare card here



NAME OF BENEFICIARY _____

CLAIM NUMBER _____

SEX _____

IS ENTITLED TO _____

EFFECTIVE DATE _____

HOSPITAL INSURANCE _____

MEDICAL INSURANCE _____

Requested effective date, or end date of prior Medicare supplement, if replacing

_____/_____/_____

Name (as it appears on your Medicare card)

Social Security Number

Home Address, Apt. No., Suite No.

City

County

State

Zip

Billing Address (if different from home address)

City

County

State

Zip

Care of/Attention

Home Telephone Number
()

E-mail Address

Date of Birth

If transferring from another Blue Cross Group/Individual or Blue Cross/Blue Shield out-of-state plan, indicate

Group Number

State

Certificate Number

Section 2 – Billing Information

Blue Cross Use Only

Broker No.

Contract No.

H/S

Yes No

Amount Received

\$

Group No.

Certificate No.

Effective Date

X Re. Cert. No.

Insert check face up. Please submit one month's premium. Check must be made payable to Blue Cross.

If you are applying for a 2-party contract, or wish to be added to an existing contract, please enclose one check for the applicable 2-party rate.

Section 3 – Health History

You must already be enrolled in Medicare Parts A and B to apply for these plans. All applicants must complete sections 3 and 4. If the answer to any of the following questions is “Yes”, you are not eligible for coverage. We will not deny coverage to any individual who applies for coverage if you are applying from certain Blue Cross Plans that are not Medicare Supplements or you are 65 or older and applying within six (6) months of your initial enrollment in Medicare Part B. You must already be enrolled in Medicare Parts A and B to apply for these plans. **Applicant must complete this section.**

- | | Yes | No |
|--|--------------------------|--------------------------|
| A. 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements.) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin’s disease, coronary artery disease, heart attack, nephritis, kidney failure, stroke or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past 5 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer’s disease, senility, dementia, Parkinson’s disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, organ transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 4 – Medical Information

Name of Primary Care Physician _____ Telephone (_____) _____

Address _____

List all prescription drugs currently prescribed for your use: (If none, write “none”) _____

List name, address and telephone number of prescribing physician if different from above:

- | | Yes | No |
|---|--------------------------|--------------------------|
| If applying for, but not accepted for Blue Cross Senior Classic I or Blue Cross Senior Classic J , if I qualify, I would like to be enrolled in: Blue Cross Senior Classic F _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Blue Cross Senior Classic C _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Please read the following carefully.

- A.** I agree to pay an application fee equal to the subscription charges required for the program requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the subscription charges if my application is accepted.
- B.** Blue Cross has the right to reject my application. If Blue Cross rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if Blue Cross rejects my application, under no circumstances will any Blue Cross benefits be payable. ***Cashing of my check by Blue Cross does not constitute approval of my application.***
- C.** If my application is accepted, this application will become part of the agreement between Blue Cross and myself. If this application is accepted, I further agree to be bound by the arbitration clause set forth in Section 7 of this application and I waive my right to court trial by judge or jury in the event of any dispute arising under this policy.
- D.** Blue Cross may request additional information, which may delay processing of this application. If the health care provider bills for this information, Blue Cross will pay up to \$25 and I understand that I will be responsible for any difference.
- E.** The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or terms of any Blue Cross coverage.
- F.** I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted and that Blue Cross may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions regarding my past or present health conditions.
- G. California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.**

Important Information for Applicant (Please read)

- You do not need more than one Medicare supplement policy or contract.
- If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare supplement policy or contract.
- The benefits and premiums under your Medicare Select contract or Standard Plan A will be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your contract will be reinstated if requested within 90 days of losing your Medi-Cal or Medicaid eligibility.
- Counseling services may be available in your area to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medi-Cal or Medicaid program, including 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.

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex), but not including psycho therapy notes.

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker, for the purpose(s) described below.

Purpose of this Authorization: By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Effect of Declining: If I decide not to sign this authorization, you may decline to enroll me in our health plan. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon termination of any Blue Cross coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Blue Cross of California
PO. Box 9063, Oxnard, CA 93031-9063
Telephone 800-333-3883, Fax 805-375-0361

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

Section 6 – Authorization & Agreements (continued)

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

If the authorization is signed by a personal representative, on behalf of the individual, complete the following:

<input type="text"/>	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
Print Applicant's Name		Applicant's Signature	Date

Name of the other person or persons authorized to receive my PHI:

<input type="text"/>	<input type="text"/>
Name of other person authorized to use or disclose my PHI	Relationship to Applicant

<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>
	Applicant's Signature	Date

A photocopy of this authorization is as valid as the original, and I and my Blue Cross agent or broker are entitled to receive a copy of this form. I AM ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER I SIGN IT.

- I have personally read and completed this application. I understand and agree to the Replacement Notification, the Conditions of Application and the Authorization. I acknowledge receipt of the “Guide to Health Insurance for People with Medicare”, the Provider Directory, the Medicare Select and Standard Plan A Disclosures, the Medicare Select Review and Grievance Procedures and “Outline of Medicare Select Coverage and Premium Information” as required by California Health and Safety Code. I understand that receipt of money with this application does not create Blue Cross coverage. Coverage will come into effect only if this application is approved by Blue Cross of California.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety.

Section 7 – Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. The Member and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

The Member and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member. The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings. The arbitration is initiated by the Member making written demand on Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Blue Cross, or by order of the court, if the Member and Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Blue Cross will assume all or a portion of the costs of the arbitration. Please send all Binding Arbitration demands in writing to:

Blue Cross of California
P.O. Box 9053, Oxnard, CA 93031-9053

X

Applicant's Signature

Date of Signature

ANSWER ALL QUESTIONS IN THIS SECTION

To the best of your knowledge:

Do you have another Medicare supplement/Select or Standard Plan A insurance policy or health care service plan in force? Yes No

If yes, insurance company's name _____

Street Address _____

City _____ State _____ Zip _____

(Attach additional sheets if necessary.)

Do you have any other health coverage that provides benefits that the Medicare Select contract or Standard Plan A would duplicate? Yes No

If yes, with which company _____ What kind of coverage _____

Address _____ Phone Number (_____) _____

If the answer to either of the above questions is yes, do you intend to replace any of your medical or health insurance coverage with this policy? Yes No

Please be aware that if you are currently enrolled in a Medicare Risk HMO plan, including Blue Cross Senior SecureSM, it is your responsibility to terminate your coverage prior to enrollment becoming effective with Blue Cross. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.

Are you covered by Medi-Cal or Medicaid? Yes No

If yes, do you qualify for Qualified Medicare Beneficiary (QMB) assistance, Specified Low-Income Medicare Beneficiary (SLMB), or other Medi-Cal or Medicare benefits?

Optional Monthly Checking Account Deduction Authorization for Seniors.

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Subscriber	
Group Number	
X	Date

Social Security Number	
Bank Name	
X	Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free 1-800-927-HELP, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free 1-800-434-0222, or by accessing the Department of Insurance's web site www.insurance.ca.gov.

For Agent Only

Please list all disability policies you have issued to the applicant that are still in force and all disability policies issued in the past 5 years that are no longer in force and submit with the application, as required by Insurance Code Section 10197(c):

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr.		Name
		Address
		City/State
To: Mo./Yr.		

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the applicant the "Guide to Health Insurance for People with Medicare" and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

		SIGNED AT	
Agent's Signature	Date of Signature	(City and State)	
Print Agent's Name	Agent No.		
Street Address	Telephone No.		
City	State	ZIP	
Amount Paid With Application \$ _____			
Send Agreement and I.D. Card To: <input type="checkbox"/> Agent <input type="checkbox"/> Subscriber			
Name of person who completed this application: _____			

MAILING ADDRESS – Applicant: Please return application to agent or mail to:

Blue Cross of California
P.O. Box 9063, Oxnard, CA 93031-9063



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PRIORITY PROCESSING

Complete the Other Side of this form to enroll in the Optional Monthly Checking Account Deduction Authorization for Seniors.

Include with one month's dues in application pocket behind check.

Include a blank check marked "VOID".

A deposit slip is not acceptable.

THIS APPLICATION WILL BE RETURNED TO YOU AFTER PROCESSING. WE ADVISE YOU TO SAVE THIS NOTICE AS IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you have furnished, you intend to lapse or otherwise terminate an existing Medicare supplement policy or plan contract and replace it with a contract to be issued by Blue Cross of California. Your plan contract to be issued by Blue Cross of California will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Standard Plan A or Medicare Select coverage is a wise decision.

Statement to applicant by plan, solicitor, solicitor firm, or other representative:

A. I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement contract is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other. (Please specify.) _____

B. You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.

C. State law provides that your replacement Medicare Select or Standard Plan A contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

D. If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

E. Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.



Blue Cross Senior Services
Toll-Free Number

Monday – Thursday:
8:00 a.m. to 6:00 p.m.

Friday:
8:00 a.m. to 3:00 p.m.

(800) 333-3883