

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 **(888) 713-0000** [TDD: (888) 595-0000].

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	
Mailing Address (if different from above)			
City	State	Zip	
Home Telephone ()	E-mail	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	

4.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have another Medicare supplement policy or certificate or contract in force?
	IF YES,	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	a.) With what company, and what plan do you have?
	<input type="checkbox"/> Yes <input type="checkbox"/> No	b.) Do you intend to replace your current Medicare Supplement policy or certificate with this contract?
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? If so, what companies and what kind of policy? _____ _____
		What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) Start _____ End _____
6.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Did you have Medicare coverage before age 65?
	IF YES,	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	a.) Why? _____
	<input type="checkbox"/> Yes <input type="checkbox"/> No	b.) What is the current status? _____

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.	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
	<input type="checkbox"/> Yes <input type="checkbox"/> 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.*
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cancer or malignant tumors.
	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you received treatment or been hospitalized for any other condition than those listed above?
2.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.	<input type="checkbox"/> Yes <input type="checkbox"/> 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.

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. If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can 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 suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. If you are eligible for, and have enrolled in, a Medicare supplement contract 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 contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. 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. 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

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.

Expiration: This authorization will remain valid until 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.

SIGNATURE

Applicant's Signature

Date

PRODUCER INFORMATION

Agent/Broker Name		Agent/Broker ID
Agent/Broker Phone #	Agent/Broker Fax #	
Agent/Broker Address		
Agent/Broker Signature		
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: _____ _____		

PAYMENT 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\$PaySM (automatic monthly debit – you must complete the enclosed form)
 Credit card payment (automatic monthly or quarterly charge – you must complete the enclosed form)
 Quarterly billing Monthly billing

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.