

Application for Medicare Supplement Insurance Plan



BlueCross BlueShield of Oklahoma

Instructions

Complete this application in ink and sign on the appropriate line in PART THREE. To be considered for coverage, you must be age 65 or over, reside in Oklahoma and have Medicare Parts A and B.

Plan65

Blue Plan65 Select

Medicare Supplement

PART ONE Send no money now! No payment is due until you review your coverage.

SECTION A. Plan Selection

I would like to apply for Medicare Supplement: *(check only one box)*

- Plan A Plan F Plan F High Deductible Plan N
- Blue Plan65 Select F Blue Plan65 Select N

Make policy effective:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH		DAY		YEAR	

PAYMENT OPTION

I prefer to be billed: *(Please select one)* Monthly Every three months Every six months

Select a method of payment:

Deduct from my checking account

Bank Name _____

City _____ State _____

Routing # _____ Acct. # _____

Bill me at my home address

Bill to my Blue Cross and Blue Shield group *(see your employer/group benefits administrator for available coverage options).*

Group Name _____

Group Number _____

SECTION B. Personal Information

Name

Address 1

Address 2

City County

State ZIP

Telephone ()

Male Female

Birthdate
MONTH DAY YEAR

Height ft. in. Weight lbs.

Social Security No.

SECTION C. Medicare Claim Number and Effective Date

Please see your Medicare card for this information.

Copy the Medicare Claim Number and Part A and B effective dates from your red, white and blue Medicare card. This information must be provided for us to complete your application process.

Your Medicare Claim No.

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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(please include any prefixes or suffixes)

Your Medicare Part A effective date

<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH		DAY		YEAR			

Your Medicare Part B effective date

<input type="text"/>	<input type="text"/>	<input type="text" value="0"/>	<input type="text" value="1"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
MONTH		DAY		YEAR			

SECTION D. Consumer Protection Information

Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.

- 1. Do you have another Medicare Supplement policy in force? Yes No
 - a. If yes, with what company, and what plan do you have?
 - b. If yes, do you intend to replace your current Medicare Supplement policy with this policy? Yes No
- 2. Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? Yes No
 - a. If yes, which company provides the health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? _____
 - b. If yes, what type of policy is it? Group Individual Other
- 3. Do you have or have you had a Blue Cross and Blue Shield of Oklahoma health insurance policy? Yes No
If yes, what type of policy?
- 4. Are you covered for medical assistance through the state Medicaid program? Yes No
{NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.}
 - a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
 - b. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

SECTION E. Guaranteed Issue Eligibility

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 insurance 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. Please mark Yes or No with an "X" 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?
MONTH DAY YEAR

If yes, you are eligible for Guarantee Issue and are not required to complete the Part Two "Health History" Section.

PART ONE Section E Continued

Please attach supporting documentation if you answer yes to questions 3, 4 or 5 below.

3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. (If you are still covered under this plan, leave "END" blank.)

START END

MONTH DAY YEAR MONTH DAY YEAR

- a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? Yes No
 - b. Was this your first time in this type of Medicare plan? Yes No
 - c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No
4. Have you had coverage under any other health insurance within the past 63 days? Yes No

(For example, an employer, union, or individual plan)

a. If so, with what company and what kind of policy? _____

b. What are your dates of coverage under the other policy?
(If you are still covered under the other policy, leave "END" blank.)

START END

MONTH DAY YEAR MONTH DAY YEAR

5. Have any of the following events listed below occurred? Yes No

If so, and if you are applying before the 63rd day after your coverage terminated, you are an Eligible Person for Guaranteed Issue.

- Were you enrolled in employer/retiree group health coverage (including COBRA coverage) and canceled because you could no longer be covered under the terms of the plan, voluntarily left the plan, the company is canceling the company plan in its entirety, or your COBRA coverage ended?
- Were you enrolled in a Medicare Advantage (including Medicare HMO or PPO) plan, a Medicare Select plan or a PACE program when you were age 65 or older and were you disenrolled because (1) you moved out of the service area, (2) your plan withdrew from your service area, (3) the certificate of the organization or plan has been terminated, (4) the organization violated a material provision of the organization’s contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to you, including failure to provide you on a timely basis medically necessary care for which benefits are available under the plan or to provide such covered care in accordance with applicable quality standards, (5) the organization, agent or other entity acting on the organization’s behalf, materially misrepresented the plan’s provisions in the marketing plan or (6) you enrolled for the first time since you became Medicare Eligible at age 65 or older and decided to disenroll within one year of initial enrollment?
- Did you have a Blue Cross and Blue Shield of Oklahoma Medicare Supplement plan and then you canceled it to enroll, for the first time, in a Medicare Advantage (including Medicare HMO or PPO) plan, a Medicare Select plan or a PACE program within the last 12 months, and then you disenrolled from your new plan within one year of initial enrollment?

Please note: If you were involuntarily terminated within the first 12-month period and, without intervening enrollment, enrolled with another such organization, the subsequent enrollment shall be deemed to be the initial enrollment.

- Were you enrolled in a Medicare Supplement plan and your previous carrier ended your coverage through no fault of your own, including the carrier violating a material provision of the policy, or the carrier, agent or other entity acting on the carrier’s behalf materially misrepresented the policy’s provisions in marketing the policy?
- Were you enrolled in a Medicare Part D plan during the initial enrollment period, had a Blue Cross and Blue Shield of Oklahoma Medicare Supplement policy with outpatient prescription drug coverage during such period, but terminated the Blue Cross and Blue Shield of Oklahoma Medicare Supplement policy because of the Part D plan prior to 63 days after the effective date of your coverage under Medicare Part D?
- Are you over age 65, covered under Medicaid but have lost Medicaid entitlement, and are enrolled in Medicare Parts A and B?
- Are you under age 65, covered under Medicaid but have lost Medicaid entitlement, and are enrolled in Medicare Parts A and B? (You are eligible for Plan A only.)

PART TWO

HEALTH HISTORY/ MEDICAL QUESTIONS



If you are in your Medigap Open Enrollment or if you have determined that you are eligible for Guaranteed Issue based on SECTION E, "Guaranteed Issue Eligibility," you are not required to answer the following health questions. Please continue to PART THREE.

Please answer the following health history questions.

1. When you first became eligible for Medicare, was it either because of disability or end stage renal disease? Yes No

2. Within the past 5 years, have you been diagnosed, treated, hospitalized or recommended for treatment, including drug therapy, by a physician or any other provider for any of the following:

	Yes	No		Yes	No
a. Diabetes with amputation, loss of sight or complications affecting the kidney?	<input type="checkbox"/>	<input type="checkbox"/>	i. Congestive heart failure or heart valve replacement?.....	<input type="checkbox"/>	<input type="checkbox"/>
b. Organ or tissue transplant (except cornea)?..	<input type="checkbox"/>	<input type="checkbox"/>	j. Nephritis or kidney failure?.....	<input type="checkbox"/>	<input type="checkbox"/>
c. Cancer (excluding basal cell or squamous cell cancer of the skin)?	<input type="checkbox"/>	<input type="checkbox"/>	k. Cirrhosis of the liver or Hepatitis C?.....	<input type="checkbox"/>	<input type="checkbox"/>
d. Leukemia or Hodgkin's disease?.....	<input type="checkbox"/>	<input type="checkbox"/>	l. Multiple Sclerosis or neuromuscular disorders?..	<input type="checkbox"/>	<input type="checkbox"/>
e. Stroke, Transient Ischemic Attack (TIA)?.....	<input type="checkbox"/>	<input type="checkbox"/>	m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)?.....	<input type="checkbox"/>	<input type="checkbox"/>
f. Alzheimer's disease, senility, dementia or brain disorder?	<input type="checkbox"/>	<input type="checkbox"/>	n. Respiratory or lung disease requiring use of oxygen?	<input type="checkbox"/>	<input type="checkbox"/>
g. Parkinson's disease?	<input type="checkbox"/>	<input type="checkbox"/>	o. Alcohol or chemical dependency?	<input type="checkbox"/>	<input type="checkbox"/>
h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty?.....	<input type="checkbox"/>	<input type="checkbox"/>			

3. Within the past 5 years, have you been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection? Yes No

4. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement, or surgery for the heart, arteries or intestines that has not yet been done?. Yes No

5. Within the past 2 years, have you been hospitalized 2 or more times, or have you been confined to a nursing home for 14 or more days?..... Yes No

6. 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 or a home health care agency?..... Yes No

7. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty?
 - Taking Medications • Eating • Walking • Moving from place to place in your home
 - Getting in and out of bed or chairs • Bathing • Dressing • Toileting. Yes No

PART THREE - REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I have read and understand the statements below regarding Medicare Supplement coverage from Blue Cross and Blue Shield of Oklahoma, which is herein called the Company. I have received an Outline of Coverage for the policy I applied for.

Medical Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information. I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Important Information Regarding Medicare Supplement Coverage: 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 if you need more than one type of coverage in addition to your Medicare benefits. 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 can 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. 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 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 outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Statements

A) You do not need more than one Medicare supplement policy. (B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. (C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy. (D) If after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can 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. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy will be reinstated if requested within 90 days of losing Medicaid eligibility. 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 outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. (E) 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 ninety (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 outpatient prescription drug coverage, but will otherwise be equivalent to your coverage before the date of the suspension. (F) Counseling services

PART THREE Continued

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).

AGREEMENTS AND SIGNATURES

- I understand that if I apply for Part A and B of Medicare and am not accepted, or at a future date lose Medicare entitlement, Plan65 will be of no value to me; therefore, it will be my responsibility to notify Blue Cross and Blue Shield of Oklahoma (hereafter referred to as BCBSOK) to terminate my Plan65.
- Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- I hereby apply for membership with BCBSOK as stated in this application. I agree that if my application is accepted, membership will not be effective until the date indicated in written notification by BCBSOK at time of acceptance.
- Physicians, hospitals and other institutions are hereby authorized and have my consent to release, disclose and furnish to BCBSOK for its review and retention in connection with my application for health coverage, all information, records or copies of records relating to my medical history and conditions, including, but not limited to, diagnosis, treatment, care, surgery, and the dates thereof, past, present and future.
- I understand BCBSOK may deny benefits for the treatment of any condition which is not correctly represented in this application, and has the right to cancel membership and coverage and to recoup any monies paid as benefits prior to a determination by the Plan that a condition required to be reported was not correctly represented.
- Proof of Disclosure (for Blue Plan65 Select applicants only): I acknowledge that I have carefully and completely read and understand the Blue Plan65 Select Outline of Coverage and Provider Directory that were sent to me with this application. I am aware of and understand the restrictions of the Blue Plan65 Select provider directory. **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, make any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

SIGNATURE *Must be signed and dated to avoid delays in processing.*

Please sign here in ink: X _____ Date Signed: _____ / _____ / _____
SIGNATURE OF APPLICANT MONTH DAY YEAR

Please print your name here: _____ Phone Number: (____) _____
NAME OF APPLICANT AREA CODE

PROXY STATEMENT: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof (“HCSC”), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned’s proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant’s Signature X _____

Print Your Name as You Signed It: _____ Date Signed: _____ / _____ / _____
MONTH DAY YEAR

I have reaffirmed that the information supplied on this application is accurate and complete.

Agent Signature: X _____ Date Signed: _____ Phone Number _____

Print Agent Name: _____ Agent Code: _____ Firm Name: _____

FOR PRODUCER USE ONLY (IF APPLICABLE)

**NOTICE TO APPLICANT REGARDING
REPLACEMENT OF MEDICARE SUPPLEMENT
INSURANCE OR MEDICARE ADVANTAGE**



**BlueCross BlueShield
of Oklahoma**

Please retain copies of this form for both you and your applicant's records.

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Oklahoma. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and health coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement, or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment: _____

Other (please specify): _____

1. Note: If the issuer of the Medicare supplement policy applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy 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.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

PRODUCER'S SIGNATURE X _____ DATE SIGNED: _____

APPLICANT'S SIGNATURE X _____ DATE SIGNED: _____

FOR PRODUCER USE ONLY (IF APPLICABLE)

**PLAN65 MEDICARE SUPPLEMENT INSURANCE
PRODUCER'S SUPPLEMENTARY APPLICATION FORM**

Please retain copies of this form for both you and your applicant's records.

APPLICANT AND PRODUCER HEREBY ACKNOWLEDGE THE FOLLOWING:

1. Producer inquired and made every reasonable effort to identify whether the Applicant already has accident and sickness insurance and the types and amounts of any such insurance. NOTE: If this policy is replacing another Medicare supplement insurance policy or Medicare Advantage insurance, Producer must complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."
2. Producer has sold the following medical or health insurance policies to the Applicant which are still in force.

3. Producer has sold the following medical or health insurance policies to the Applicant in the past five years which are no longer in force: _____
4. Producer furnished to the Applicant (and Applicant acknowledges receipt of the following documents:
 - Outline of Coverage
 - Guide to Health Insurance for People with Medicare (Buyer's Guide)
 - Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage
(Complete only if Applicant is replacing an existing Medicare supplement policy)

PRODUCER'S SIGNATURE X _____ DATE SIGNED: _____

APPLICANT'S SIGNATURE X _____ DATE SIGNED: _____