



# Plan65

BLUE PLAN65 SELECT

*Experience. Wellness. Everywhere.<sup>SM</sup>*

Application for Plan65 Membership



**BlueCross BlueShield  
of Oklahoma**

**Ron Powell & Associates LLC**

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**BlueCross BlueShield  
of Oklahoma**

**Blue Cross and Blue Shield of Oklahoma — Plan65**  
P.O. Box 806162, Chicago, IL 60680-8784

# Plan65

*Blue*  
**Plan65** *Select*  
Medicare Supplement

## YOU MAY APPLY FOR PLAN65 COVERAGE IF:

You have Medicare Parts A and B; **AND**,  You are an Oklahoma resident; **AND**,  You are age 65 or older.

## SELECT YOUR COVERAGE:

Plan A    Plan D    Plan F  
 Plan F (high deductible)    **Blue Plan65 Select**

## MAKE POLICY EFFECTIVE:

\_\_\_\_ - \_\_\_\_ - \_\_\_\_  
MONTH      DAY      YEAR

## SELECT ONE PAYMENT OPTION:

<p>A. Deduct from my checking account:</p> <p><input type="checkbox"/> MONTHLY</p> <p><input type="checkbox"/> 3 MONTHS</p> <p><input type="checkbox"/> 6 MONTHS</p>	<p>B. I prefer to be billed at my home:</p> <p><input type="checkbox"/> MONTHLY</p> <p><input type="checkbox"/> 3 MONTHS</p> <p><input type="checkbox"/> 6 MONTHS</p>
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C. Bill to my Blue Cross and Blue Shield group (see your employer / group benefits administrator for available coverage options).

\_\_\_\_\_

NAME OF GROUP TO BE BILLED      GROUP NUMBER

<b>MEDICARE HEALTH INSURANCE</b>	
<b>SAMPLE ONLY</b>	
Name: _____	
Medicare Claim Number	Sex <input type="checkbox"/>
□□ □□□ - □□ - □□□□ □□	
Is Entitled to	Effective Date
<b>HOSPITAL (Part A)</b>	_____
<b>MEDICAL (Part B)</b>	_____

## TELL US ABOUT YOURSELF:

FIRST NAME OF APPLICANT	MIDDLE	LAST
MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)		
SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH mm/dd/yyyy __ / __ / ____	SOCIAL SECURITY NUMBER □□□□ - □□ - □□□□

## FINANCIAL INSTITUTION DEBIT AUTHORIZATION

**PLEASE TAPE  
CHECK HERE**

### REMINDER

Your **VOIDED CHECK** (personal checking) or savings deposit slip must be attached here.

Please attach check with **TAPE**. Do not use glue, staples or paper clips.

Your Name Your Address Your City, State & Zip	
Pay to the Order of _____	\$ _____ Dollars
DEPOSITORY BANK OR BRANCH NAME BANK ADDRESS _____	
⑆ 2345678	⑆ 23456 0 ⑆ 00⑆

# PLEASE ANSWER ALL THE FOLLOWING QUESTIONS:

To the best of your knowledge:

[Please mark Yes or No below with an "X"]

1. Have you been diagnosed with end-stage renal disease?.....  Yes  No
2. Did you turn age 65 in the last 6 months?.....  Yes  No
3. Did you enroll in Medicare Part B in the last 6 months? .....  Yes  No  
(a) If yes, what is the effective date? \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
4. Do you have another Medicare supplement policy in force? .....  Yes  No  
(a) If so, with what company, and what plan do you have? \_\_\_\_\_  
(b) If so, do you intend to replace your current Medicare supplement policy with this policy?.....  Yes  No
5. Are you covered for medical assistance through the state Medicaid program?  
[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.].....  Yes  No  
(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

## Please attach supporting documentation if you answer yes to questions 6, 7 or 8 below.

6. Have 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)? .....  Yes  No  
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare plan? .....  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 this Medicare plan? .....  Yes  No
7. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan).....  Yes  No  
(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" date blank.) START \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ END \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_
8. If you lost or are losing other health insurance coverage, did you receive 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? .....  Yes  No  
If so, 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.

## 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.

Statements continue on next page

- (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 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 booklet and 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.**

I CERTIFY THAT ALL STATEMENTS AND INFORMATION SET FORTH ARE TRUE AND CORRECT

APPLICANT'S SIGNATURE X \_\_\_\_\_ DATE SIGNED: \_\_\_\_\_

RESIDENCE PHONE NUMBER: \_\_\_\_\_ ALTERNATE PHONE: \_\_\_\_\_

**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: \_\_\_\_\_

FOR OFFICE USE ONLY	REP NO.	EFFECTIVE DATE	GROUP NO.	MISC CODE
FOR PRODUCER USE ONLY	PRODUCER NAME Ron Powell / Ron Powell & Associates		PRODUCER SIGNATURE	PRODUCER ID NO. 01308000

**FOR PRODUCER/AGENT 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/AGENT USE ONLY (IF APPLICABLE)

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



**BlueCross BlueShield  
of Oklahoma**

**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.

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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:

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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: \_\_\_\_\_



**BlueCross BlueShield  
of Oklahoma**