BlueCross BlueShield of Texas

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please fax or email this cover letter with the completed application to:

FAX#: (847) 220-9280 or email a scanned copy to help@ilhealthagents.com

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

❑ Please contact me at this phone number after you have reviewed my application for completeness and accuracy _____.

❑ Please contact me at this email after you have reviewed my application for completeness and accuracy _____.

BlueCross BlueShield of Texas

Application for Medicare Supplement Insurance Plan

Instructions

1. To be considered for coverage, you must have Medicare Parts A and B, reside in Texas, and be: a) age 65 or over or b) applying within 6 months of your Medicare Part B effective date.
2. **If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) on pages 3, 4, and 8.** Send no money now! No payment is due until you have a chance to review your policy and make sure the coverage is right for you.
3. If you meet the eligibility requirements for under age 65 disability, you are only eligible for Plan A.

HOME OFFICE USE ONLY

Plan Selection *Check one box to apply for a Medicare Supplement Insurance plan.*

- ☐ **Plan A**
- **Plan F**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **Plan F High Deductible**
- **Plan G**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan K**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan L**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan N**
  - ☐ Standard
  - ☐ Medicare Select

Requested Policy Effective Date ☐☐ ☐☐ ☐☐☐☐ *MONTH DAY YEAR*

See the enclosed Outline of Coverage for rate information

Applicant Information

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email

Name *(First)*	*(Middle)*	*(Last)*		
Home Address (No P.O. Boxes)		City	State **TX**	ZIP
Correspondence/Billing Address		City	State	ZIP
Primary Phone ( )	Secondary Phone ( )	Age	Date of Birth ___ ___/___ ___/___ ___ ___ ___ Mo. Day Year	
Gender Male ☐ Female ☐	Social Security Number ___ ___ ___ -___ ___ -___ ___ ___ ___	Email address		

Payment Option *(Select one payment option)*

1. ☐ Premium **deducted from bank account**: *(choose one)*: ☐ ***Checking*** ☐ ***Savings***

   Account holder name: _____

   Bank name: _____

   Bank routing #: _____ Bank account #: _____

   Account Owner Signature *(if different than applicant)* **X** _____

2. ☐ Premium **to be billed by mail**

3. I will pay my premium: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Applicant Name _____

Medicare Beneficiary Identifier

Please copy the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Medicare Beneficiary Identifier ☐☐☐☐☐☐☐☐☐☐☐

Part A Effective Date: ___/01/_____

Part B Effective Date: ___/01/_____

Consumer Protection Information

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 below 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? ___/___/_____

3. 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 ☐

4. 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. *(If you are still covered under this plan, leave "END" blank.)*

Start: ___/___/_____

End: ___/___/_____

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 ☐

5. Do you have another Medicare Supplement or Medicare Advantage 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 or Medicare Advantage policy with this policy? Yes ☐ No ☐

6. Have you had coverage under any other health insurance within the past 63 days? Yes ☐ No ☐

a. If so, with what company, and what kind of policy?
(For example, an employer, union, or individual plan) _____

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: ___/___/_____

Applicant Name _____

STATEMENTS

1. You do not need more than one Medicare Supplement policy.
2. 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.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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 reinstituted if requested within 90 days of losing Medicaid eligibility.*
5. 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 reinstituted 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 reinstituted policy 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 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). For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

Questions?

Call us at our Customer Service toll-free number 800-654-9390, call your insurance agent at the number listed on the next page, or visit *www.bcbstx.com*.

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.

Applicant Signature *(optional)*: **X** _____

Print Your Name as You Signed It: _____ Date: ___ ___/___ ___/___ ___ ___ ___

Applicant Name _____

Acknowledgements and Signature

1. I hereby apply for coverage and request a policy to review for the Medicare Supplement policy indicated.
2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.
3. I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.
4. I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.
5. I acknowledge that I have read and understand the Statements section regarding Medicare Supplement coverage. If eligible for a Medicare Select Plan, I have also read and understand the statements regarding Medicare Select as described in the Outline of Coverage. WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.
6. I acknowledge that any agent is acting on my behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
7. I acknowledge if I desire additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, I should contact the agent.
8. I acknowledge that I have received a copy(s) of the Medicare Supplement Buyers Guide.
9. ☐ **Outline of Coverage:** I acknowledge receipt of Outline of Coverage.

SIGNATURE REQUIRED

*Must be signed **in ink** and dated to avoid processing delays. For Power of Attorney and Legal Guardianships, be sure to submit copies of the court documents with the application.*

Applicant X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Agent Information *(If Applicable)*

The following information is to be filled out by an agent, if Applicant is purchasing coverage through an agent.

Please list any other health insurance policies or coverages sold to the applicant which are still in force:

_____

Please list any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

_____

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

Agent Signature: X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Print name: Ryan Kennelly Broker Code: 061472000

Agency name *(If Applicable)*: Independent Health Agents Phone: (312) 588-9915

PLEASE CONTINUE ON PAGE 5 IF YOU ARE NOT NEWLY ELIGIBLE TO ENROLL IN MEDICARE DUE TO AGE OR DISABILITY.

Applicant Name _____

Guaranteed Issue Eligibility

Please mark Yes or No to questions 1-9 with an "X". If you answer "Yes" to any and if you are applying before the 63rd day after your coverage terminated, you are eligible for guaranteed issuance of this Medicare Supplement policy. If you are eligible for guaranteed issuance of this policy, do not complete the Health History/Medical Questions that start on page 6. Proceed to page 8 and sign the Medical Authorization.

Have any of the following events listed below, and on the next page, occurred?

Yes ☐ No ☐ **1.** The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

Yes ☐ No ☐ **2.** The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual was enrolled in a Medicare Advantage plan: (A) the certification of the organization or plan has been terminated; or (B) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; (C) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851 (g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area; (D) the individual demonstrates, in accordance with guidelines established by the Secretary, that: (i) the organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or (ii) the organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or (E) the individual meets such other exceptional conditions as the Secretary may provide.

Yes ☐ No ☐ **3.** The individual is enrolled with an entity listed in subparagraphs (A)-(D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection: (A) an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost); (B) a similar organization operating under demonstration project authority, effective for periods before April 1, 1999; (C) an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or (D) an organization under a Medicare Select policy; and

Yes ☐ No ☐ **4.** The individual is enrolled under a Medicare supplement policy and the enrollment ceases because: (A) of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of other involuntary termination of coverage or enrollment under the policy; (B) the issuer of the policy substantially violated a material provision of the policy; or (C) the issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

Applicant Name _____

Yes ☐ No ☐ **5.** The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851 (e) of the Social Security Act); or

Yes ☐ No ☐ **6.** The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan no later than 12 months after the effective date of enrollment.

Yes ☐ No ☐ **7.** The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D along with the application for a policy described in subsection (c)(4) of this section.

Yes ☐ No ☐ **8.** The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

Yes ☐ No ☐ **9.** The individual meets the following requirements: (A) the individual was enrolled in both the federal Medicare program and the Texas Health Insurance Pool on December 31, 2013; and (B) the individual's Pool coverage terminated on or after December 31 2013.

Health History/Medical Questions

STOP

Note: If you are eligible for Guaranteed Issue or in your Open Enrollment period, you are not required to answer the following health questions. (Continue to page 8.)

Please answer the following health history questions.

1. What is your height? ☐ Ft. ☐ In.

2. What is your weight? ☐ Lbs.

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

4. Within the past 3 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:

a. Diabetes with amputation, loss of sight or complications affecting the kidney? Yes ☐ No ☐

b. Organ or tissue transplant (except cornea)? Yes ☐ No ☐

c. Cancer (excluding basal cell or squamous cell cancer of the skin)? Yes ☐ No ☐

d. Leukemia or Hodgkin's disease? Yes ☐ No ☐

e. Stroke, Transient Ischemic Attack (TIA), or mini-stroke? Yes ☐ No ☐

f. Alzheimer's disease, senility, dementia or brain disorder? Yes ☐ No ☐

g. Parkinson's disease? Yes ☐ No ☐

h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty? Yes ☐ No ☐

i. Congestive heart failure or heart valve replacement? Yes ☐ No ☐

Applicant Name _____

PART TWO *(continued)*

j. Nephritis or kidney failure? Yes ☐ No ☐

k. Cirrhosis of the liver or Hepatitis C? Yes ☐ No ☐

l. Multiple Sclerosis or neuromuscular disorders? Yes ☐ No ☐

m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)? Yes ☐ No ☐

n. Respiratory or lung disease requiring use of oxygen? Yes ☐ No ☐

o. Alcohol or chemical dependency? Yes ☐ No ☐

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

6. 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 ☐

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

8. Are you currently confined, or has confinement been recommended within the next 6 months 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 ☐

9. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty? Yes ☐ No ☐

- Taking Medications
- Eating
- Walking
- Bathing
- Dressing
- Toileting
- Moving from place to place in your home
- Getting in and out of bed or chairs

Applicant Name _____

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 shall remain valid for 24 months, unless revoked by me in writing, which I may do at any time by sending a written request to the Company. Any revocation will not affect the activities of the Company prior to receipt of the revocation.

SIGNATURE REQUIRED

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

Applicant X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Questions?

Call us at our Customer Service toll-free number 800-654-9390, call your insurance agent at the number listed on page 4, or visit *www.bcbstx.com*.

Checklist

- ☐ Have you signed on pages 3, 4, and 8?
- ☐ If you're working with an agent, has the agent signed on page 4 (if applicable)?
- ☐ Have you answered all Health History/Medical Questions on pages 6-7?
- ☐ Have you made sure your requested effective date on page 1 is the 1st through the 28th of the month?

Return to your agent or mail this application to:

Blue Cross and Blue Shield of Texas
P.O. Box 3003
Naperville, IL 60566-7003