Blue Cross Blue Shield of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

Blue Cross Medicare Supplement

Plans A, C, F, High Deductible-F, G and N

Application

2019

2019 Medicare supplement application

1 Applicant information

Please print in black or blue ink. All sections must be completed unless otherwise indicated. All information provided will be used and disclosed only as permitted by our *Notice of Privacy Practices* which can be found at **www.bcbsm.com**.

First name	Middle initial	Last name	Social Security number

Primary street address (cannot be a P.O. Box)	City	State	ZIP code

Mailing street address (if different from above)	City	State	ZIP code

County	Phone number	☐ Home ☐ Cell	Alternate number (optional)	☐ Home ☐ Cell

Email	☐ Male ☐ Female	Birth date

Number of months you reside in MI each year	You do not have to answer this question if you are in your open enrollment or guaranteed issue period. Have you used tobacco in any form in the past year? ☐ **Yes** ☐ **No**

Did you have a Blue Cross Blue Shield of Michigan Medicare supplement policy that terminated in the past six months? ☐ **Yes** ☐ **No**	If **yes**, enrollee ID number:

Household discount eligibility

You may be eligible for a lower premium if another person in your household currently has a BCBSM Medicare Supplement or Legacy Medigap plan. Household is defined as a single-family home, a condominium unit, or an apartment unit within an apartment complex.

Please check the box below that applies to you:

☐ I reside with a person that's currently covered under a BCBSM Medicare Supplement or Legacy Medigap plan.

Name of that person _____ Enrollee ID* number of that person _____

☐ I reside with a person that is in the process of applying for a BCBSM Medicare Supplement plan.

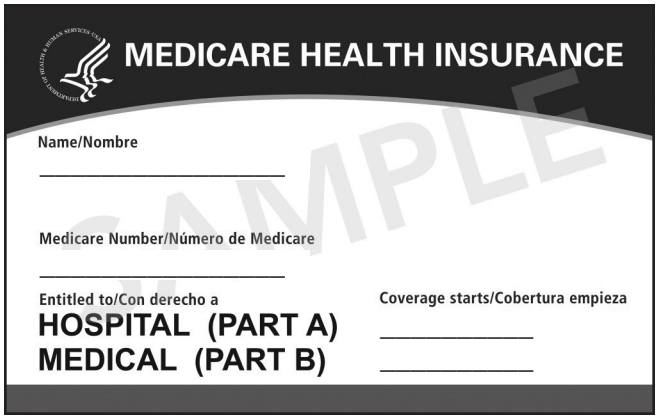
Name of that person _____ SSN of that person _____

☐ I do not currently reside with another person that has a BCBSM Medicare Supplement or Legacy Medgap plan, and I am not eligible for the household discount.

*Enrollee ID number is found on your BCBSM ID card

Please refer to your red, white and blue Medicare health insurance card to complete this section.

Please fill in these blanks so they match the information on your Medicare card.



2 Plan selection

Please check the appropriate box for the plan you are applying for:

☐ Plan A* ☐ Plan C* ☐ Plan F ☐ Plan HD-F ☐ Plan G ☐ Plan N

* If you are currently enrolled in plan A or plan C, you can stay with your plan as long as you pay your premium.

You can enroll in plan C if you'll no longer be insured because you've become eligible for Medicare or if you've lost coverage under a group policy after becoming eligible for Medicare. You're also eligible if you had plan C, then enrolled in a Medicare Advantage plan, and now would like to return to plan C. You can do this as long as it's within the first 12 months of your Medicare Advantage plan.

You're automatically eligible for plan A if you're 65 or older. If you're under 65, you're eligible for plan A if you'll no longer be insured because you've become eligible for Medicare or if you've lost coverage under a group policy after becoming eligible for Medicare. You're also eligible if you had plan A, then enrolled in a Medicare Advantage plan, and now would like to return to plan A. You can do this as long as it's within the first 12 months of your Medicare Advantage plan.

Requested effective date: ___ /_01_ /_____

When choosing a plan, it's important to know the following:

- You must be enrolled in Medicare Parts A and B.
- You cannot have more than one Medicare supplement plan.
- You cannot be enrolled in a Medicare supplement plan and a Medicare Advantage health plan at the same time.
- You must be a permanent resident of Michigan and physically reside in Michigan for at least six months of every year in order to be eligible for coverage.
- Once enrolled, if you permanently move outside of Michigan or reside in Michigan for fewer than six months of every year, your premium may change.

Coverage will only continue provided all other eligibility requirements continue to be satisfied. Refer to the *Outline of Coverage* at **www.bcbsm.com/medicare** for the monthly cost and description of the plan.

3 Medicaid information

If you are 65 or older, you may be eligible for benefits under Medicaid, and may not need a Medicare supplement plan.

Are you covered for medical assistance through the state Medicaid program? ☐ **Yes** ☐ **No**

(Note: If you are participating in a spend-down program and have not met your cost share, please answer "No" to this question.)

If **yes:** Will Medicaid pay your premiums for this Medicare supplement plan? ☐ **Yes** ☐ **No**

Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

If, after purchasing this plan, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement plan will be suspended 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 plan may be available. If it is no longer available, a substantially equivalent plan 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 re-instituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

4 Open enrollment period

A. Will you be 65 or older by (or on) the **first** day of the month following your effective month?

☐ **Yes** ☐ **No,** I am under 65 and eligible for Medicare due to disability or ESRD.

B. Are you turning 65 the same month or **no more than 6 months prior** to the first day of your requested effective month?

☐ **Yes** ☐ **No,** I turned 65 more than 6 months ago.

C. Is your Medicare Part B effective date the same month or **no more than 6 months prior** to the first day of your requested effective month?

☐ **Yes** ☐ **No,** I enrolled in Part B more than 6 months ago.

5 Guaranteed issue rights

A. Do you have another Medicare supplement policy in force? ☐ **Yes** ☐ **No**

If so, with what company, and what plan do you have? _____

_____

If so, do you intend to replace your current Medicare supplement policy with this policy?

☐ **Yes** ☐ **No** (If no, you are not eligible for this Medicare supplement plan.)

If the Medicare supplement plan has ended, why did it end?

☐ Through no fault of your own

☐ Company misled you or failed to follow the rules

☐ Other

B. Have you lost or are you losing other health coverage, received a notice from your previous health plan saying you are eligible for guaranteed issue of a Medicare supplement plan, or that you had certain rights to buy a guaranteed issue?

☐ **Yes.** Start date ___ /___ /___ End date ___ /___ /___

Reason for disenrollment: _____

☐ **No**

C. Are you enrolled, or were you previously enrolled, in a Medicare Advantage plan?

☐ **Yes.** Start date: ___ /___ /___

End date (if are you still covered under this plan, leave the end date blank): ___ /___ /___

If "Yes," select the reason you disenrolled.

☐ Plan is leaving Medicare.

☐ Plan is no longer offered in my area.

☐ I am moving out of the plan's service area.

☐ I replaced a Medicare supplement policy (or switched to a Medicare SELECT policy) for the first time, have been in the plan less than a year, and now wish to return to a Medicare supplement policy. This is considered a "Trial Right."

☐ Voluntary disenrollment.

☐ **No**

☐ I joined a Medicare Advantage plan (or PACE) when I was first eligible for Medicare Part A at 65, and within the first year of joining I decided to switch to Original Medicare and join a Medicare supplement plan. This is also considered a "Trial Right."

☐ Company misled me or failed to follow the rules.

☐ Other _____

_____

Important note: If you are currently enrolled in a Medicare Advantage plan and wish to enroll in Medicare supplement, you must separately disenroll in writing from Medicare Advantage. Submission of this application does not automatically disenroll you from your current Medicare Advantage insurance carrier. Call your Medicare Advantage customer service department for information on how to disenroll from that plan and prevent duplication of coverage or a lapse in coverage. Medicare Advantage plans only allow disenrollment at certain times of the year.

D. Did you have 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**

If yes, indicate your start and end dates below. If you are still covered under this plan, leave the end date blank. **Start date** ___ /___ /___ **End date** ___ /___ /___

Was this your first time in this type of Medicare plan?

☐ **Yes** ☐ **No**

Did you cancel a Medicare supplement policy to enroll in the Medicare plan?

☐ **Yes** ☐ **No**

E. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?

☐ **Yes** ☐ **No**

If so, with what company 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 date blank.)?

Start date ___ /___ /___ End date ___ /___ /___

If the plan has ended, why did it end?

☐ My coverage ended due to the death of or divorce from my spouse, or I became eligible for Medicare and my coverage is no longer available, or my employer no longer offers group coverage.

☐ I voluntarily canceled my coverage due to cost, benefits or other reason.

If you indicated your employer or group health plan is ending your coverage (through no action of your own), or that you received a notice from a prior heath plan that you have a right to buy a GI plan, please scan and email a copy of the termination notice or GI notice to **MedSuppUnderwriting@bcbsm.com** or fax it to **877-205-6651**. Be sure your first and last name are clearly legible on the email or fax.

6 Conversion rights (for Plans A and C only)

A. Are you or will you no longer be insured because you have become eligible for Medicare?
☐ **Yes** ☐ **No**

B. Have you lost or will you lose coverage under a group policy after becoming eligible for Medicare?
☐ **Yes** ☐ **No**

If yes to either of the above questions, what is the date you lost or will lose coverage? ___ /___ /___

If you are applying for Plan C, you must submit proof with your application that you have lost coverage as a result of becoming eligible for Medicare or that you have lost group coverage after becoming eligible for Medicare.

If you are applying for Plan A and are under age 65, please submit proof that you have lost coverage as a result of becoming eligible for Medicare or that you have lost group coverage after becoming eligible for Medicare.

7 Health information for non-guaranteed issue

Complete this section if you are not applying during your open enrollment or guaranteed issue period.

The information you provide is confidential and will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be viewed online at **www.bcbsm.com**.

Height: _____ ft. _____ in. Weight: _____ lbs.

A. Do any of these apply to you? Please check all that apply.

- ☐ AIDS or HIV+
- ☐ Amyotrophic lateral sclerosis (ALS)
- ☐ Cardiomyopathy
- ☐ Cerebral palsy
- ☐ Currently receiving dialysis
- ☐ Cystic or pulmonary fibrosis
- ☐ End stage renal disease
- ☐ Gaucher's or Pompe disease
- ☐ Growth hormone deficiency
- ☐ Hemophilia
- ☐ Hepatitis C
- ☐ Hospital inpatient within past 90 days
- ☐ Huntington's disease
- ☐ Kidney disease that may require dialysis
- ☐ Leukemia, lymphoma, malignant melanoma
- ☐ Muscular dystrophy
- ☐ Organ or bone marrow transplant
- ☐ Paraplegia, quadriplegia or hemiplegia
- ☐ Pulmonary arterial hypertension
- ☐ Spinocerebellar disease
- ☐ Stroke
- ☐ Other metabolic disorders
- ☐ Other neurodegenerative disorders
- ☐ **None of these apply**

B. Within the past two years, has a medical professional discussed any of the following treatment options that have not yet been addressed? Please check all that apply.

- ☐ Hospital admittance as an inpatient
- ☐ Organ transplant
- ☐ Back or spine surgery
- ☐ Joint replacement
- ☐ Surgery, radiation or chemotherapy for cancer
- ☐ Heart surgery
- ☐ Vascular surgery
- ☐ **None of these apply**

C. Have you been diagnosed or treated (including taking medication) for any of the following conditions in the past five years? Please check all that apply.

Heart or vascular conditions

- ☐ Angina or heart attack
- ☐ Atrial fibrillation or flutter
- ☐ Coronary or carotid artery disease
- ☐ Congestive heart failure (CHF)

Lung or respiratory conditions

- ☐ COPD or emphysema

Cancers or tumors

- ☐ Cancer (other than skin cancer)

Nervous system conditions

- ☐ Alzheimer's disease or dementia
- ☐ Multiple sclerosis
- ☐ Parkinson's disease

Diabetes

- ☐ With any of the following complications: circulatory problems, kidney problems or eye problems

Kidney conditions

- ☐ Chronic kidney disease

Liver conditions

- ☐ Cirrhosis

Immune system conditions

- ☐ Crohn's disease or ulcerative colitis
- ☐ Lupus
- ☐ Rheumatoid arthritis
- ☐ Other immune deficiency

Psychological conditions

- ☐ Bipolar or schizophrenia
- ☐ Major depression

☐ **None of the conditions in question C apply**

D. Do you have any of the following chronic health conditions? Please check all that apply.

- ☐ Anxiety or mild depression
- ☐ Arthritis (hip or knee)
- ☐ Asthma
- ☐ Diabetes (with no complications)
- ☐ Enlarged prostate (BPH)
- ☐ Fibromyalgia
- ☐ GERD or acid reflux
- ☐ Glaucoma or macular degeneration
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Hypothyroidism or hyperthyroidism
- ☐ Migraines
- ☐ Myasthenia gravis
- ☐ Osteoporosis
- ☐ Psoriasis
- ☐ **None of these apply**

Have you had any drugs administered in the doctor's office or hospital in the last 12 months? ☐**Yes** ☐**No**

List names of drugs if known:

Please list prescriptions you have taken in the last 12 months for chronic conditions:

Authorization for protected health information use and disclosure (required if applying outside your open enrollment or guaranteed issue period)

I understand that the following parties may need to collect information on me in regard to the proposed coverage: Blue Cross Blue Shield of Michigan and its reinsurers; any insurance support organization; any consumer reporting agency; and all persons authorized to represent these organizations for this purpose.

The following information may be disclosed to or by Blue Cross Blue Shield of Michigan: Any and all individually identifiable health information, including but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results.

Those parties who may need to collect information may disclose information to the following: Other insurers to which I have applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearing houses; or persons who perform business, professional, or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 30 months after the date it is signed.

I understand that I can revoke this authorization at any time by giving written notice on a standard form available online at **www.bcbsm.com**, or by contacting my agent. I also understand that my revocation will not affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization but if I do not provide it, I may not be eligible for enrollment. I understand that there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Applicant printed name	
Applicant signature	Date

8 Payment information

Choose one:

☐ Receive a monthly bill and pay by mail. ☐ Electronic funds transfer from your bank account each month.

On the due date for each bill, the checking or savings account you designate will be debited for the amount of your premium.

Once enrolled, you can request a monthly statement or get more information regarding your automatic bill payment plan by calling Blue Cross Medicare Supplement Customer Service at 1-888-216-4858 from 8 a.m. to 5 p.m., Monday through Friday. TTY users, call 711.

Name of financial institution	Account type ☐ Checking ☐ Savings
ABA/routing number and attached copy of a voided check	Account number

Print name	Account holder's signature	Date

Additional information

- You do not need more than one Medicare supplement plan.
- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are eligible for, and have enrolled in, a Medicare supplement plan because of a 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.
- Your coverage will automatically be renewed each year as long as you pay your premiums.
- To terminate your Blue Cross Medicare supplement plan, please notify Blue Cross Blue Shield of Michigan in writing or call customer service at 1-888-216-4858 from 8 a.m. to 5 p.m., Monday through Friday. TTY users, call 711.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and Medicaid.

9 Confirm and sign

Please read, sign and date where indicated.

My signature indicates that I have read and understand the contents of this application. I declare that the answers on this application are complete and true to the best of my knowledge and belief, and are the basis for issuing coverage. I understand that the application and amendments become a part of the contract and that if the answers are incomplete, incorrect or untrue, Blue Cross Blue Shield of Michigan may have the right to rescind my Blue Cross Medicare supplement coverage or adjust my premium.

If I cancel within the first 30 days of the effective date of this coverage, I will be entitled to a refund of my previous premium payment. *Please note: The reasonable costs for any health services paid by BCBSM during that time period will be deducted from the refund and I will be responsible for payment of reasonable fees for any health care services I received.* If I choose to cancel my coverage after the first 30 days, I understand I must write or call BCBSM Customer Service.

Any person who knowingly and with intent to defraud any health plan company or other person files an application or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand the coverage under the plan I am applying for will not take effect until issued by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan requires proper handling of personal health information for its members. Details of Blue Cross Blue Shield of Michigan confidentiality policies and procedures are available at **www.bcbsm.com**.

☐ **Yes** ☐ **No** I have received a copy of the Blue Cross Medicare Supplement plan *Outline of Coverage*.

☐ **Yes** ☐ **No** I have received the enclosed copy of *Choosing a Medigap Policy*.

Applicant's printed name	Applicant's signature	Date

You will receive an ID card and a Certificate of Coverage with a letter confirming your effective date and premium.

If you are the authorized personal representative, or have an authorized representative currently on file with BCBSM, you must provide the following information:

Personal representative's printed name			
Personal representative's signature		Date	
Street address	City	State	ZIP code
Phone	Relationship to applicant		

Applications can be submitted in the following ways:

Online: **www.bcbsm.com/medicare**

Fax: 1-866-392-7528

Mail: Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48244-0407

Agents must submit applications online at **www.bcbsm.com/agent**.

10 Agent use

Enrolling an individual in a Medicare supplement plan requires that you provide the following information.

1. Have you sold any other health plan policies to this individual that are still in force?
   - ☐ **Yes.** Policy descriptions (name of policy, policy number, start date): _____
   - ☐ **No**
2. Have you sold any health plan policies to this individual in the last five years that are not still in force?
   - ☐ **Yes.** Policy descriptions (name of policy, policy number, start and end dates): _____
   - ☐ **No**
3. I asked the applicant all the questions in this application and the answers are recorded as given to me.
   - ☐ **Yes**
   - ☐ **No**

Managing agent / General agency name (if applicable)		MA/GA 2-digit code
Email address	Primary phone	Fax
Agent's first and last name		Agent 5-digit code
Agent's signature		Date agent accepted application
Name of person who entered application online	BCBSM badge ID E_____ or C_____	BCBSM source code

Applications must be submitted online at **www.bcbsm.com/agent**, or submitted to the managing agent or general agent within 24 hours of accepting the applicant's paper application.

Notice to applicant regarding replacement of Medicare supplement coverage

Blue Cross Blue Shield of Michigan
600 East Lafayette Boulevard
Detroit, Michigan 48226

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application or the information you have furnished, you intend to drop or otherwise terminate existing Medicare supplement coverage or a Medicare Advantage plan and replace it with a new certificate to be issued by Blue Cross Blue Shield of Michigan. Your new certificate provides 30 days within which you may decide, without cost, whether you desire to keep the certificate.

You should review this new coverage carefully, comparing it with all disability and other health coverage you now have. You should terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by Blue Cross Medicare supplement agent, broker or other representative:

I have reviewed your current medical or health coverage as disclosed to me. The replacement of coverage involved in this transaction does 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, to the best of my knowledge. The replacement plan is being purchased for the following reason (check one):

☐ Additional benefits

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums

☐ Current plan has outpatient prescription drug coverage and am enrolling in Part D

☐ Disenrollment from a Medicare Advantage plan

Reason for disenrollment _____

☐ Other (please specify) _____

☐ **Did not replace existing Medicare supplement coverage**

If, after thinking about it carefully, you still wish to drop your present coverage 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 insurer to deny any future claims and to refund your premium as though your policy or certificate 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 certificate and are sure that you want to keep it.

The *Notice to Applicant* was delivered to me by my agent on (date): _____ / _____ / _____.

I delivered the *Notice to Applicant* on (date): _____ / _____ / _____.

Signature of agent, broker or other representative (signature not required for direct response sales)		Date	
Printed name of agent		Agent number	
Agent's street address	City	State	ZIP code

Applicant's signature		Date	
Printed name of applicant			
Applicant's street address	City	State	ZIP code
Policy, certificate or contract number being replaced			

Notes

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

www.bcbsm.com/medicare