

Thank you for choosing...



## Enrolling is Simple. Just Follow These 3 Easy Steps...

### Step 1

**COMPLETE THE APPLICATION IN BLUE OR BLACK INK.** Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact your agent at: (630) 930-9364.

### Step 2

**SELECT THE TYPE OF BILLING YOU WANT (Section C)** – monthly (by checking account deduction), monthly, bi-monthly (every two months), quarterly, semi-annually semi-annually (every six months), or annually.

### Step 3

**FAX THE COMPLETED APPLICATION TO:**

**Fax: (847) 220-9280**

We will be in contact with you upon receipt of your completed application. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.



## FAX COVER LETTER

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

\*\*Please FAX this cover letter with the completed application to:

**FAX#: (847) 220-9280**

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 \_\_\_\_\_.



## Instructions

- To be considered for coverage, you must be age 65 or over, reside in Texas and have Medicare Parts A and B.
- If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) in PART THREE. 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.

## PART ONE

### Section A: Plan Selection *Check one box to apply for a Medicare Supplement Insurance plan.*

<input type="checkbox"/> <b>Plan A</b>	<input type="checkbox"/> <b>Plan F</b> <input type="checkbox"/> Standard <input type="checkbox"/> Medicare Select	<input type="checkbox"/> <b>Plan F</b> <input type="checkbox"/> <b>High Deductible</b>	<input type="checkbox"/> <b>Plan G</b> <input type="checkbox"/> Standard <input type="checkbox"/> Medicare Select
<input type="checkbox"/> <b>Plan K</b> <input type="checkbox"/> Standard <input type="checkbox"/> Medicare Select	<input type="checkbox"/> <b>Plan L</b> <input type="checkbox"/> Standard <input type="checkbox"/> Medicare Select	<input type="checkbox"/> <b>Plan N</b> <input type="checkbox"/> Standard <input type="checkbox"/> Medicare Select	

Make policy effective:             

MONTH      DAY      YEAR

*See the enclosed Outline of Coverage for rate information*

### Section B: Personal Information

Name (First, Middle, Last)				
Home Address		City	State <b>TEXAS</b>	Zip
Correspondence/Billing Address		City	State	Zip
Primary Phone (    )	Secondary Phone (    )	Age	Birthdate ____/____/____ Mo.   Day   Year	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security Number ____-____-____	E-mail address		

### Section C: Payment Option *(Select One payment option)*

- Premium **deducted from my bank account:** (Financial Institution Debit Authorization)  
 Electronic Fund Transfer Account Type:     Checking     Savings  
 Account holder name: \_\_\_\_\_  
 Bank name: \_\_\_\_\_  
 Bank account number: \_\_\_\_\_ Bank routing number: \_\_\_\_\_  
 Account Owner Signature (if different than applicant) **X** \_\_\_\_\_
- Premium **to be billed by mail**
- I will pay my premium:     Monthly     Bi-Monthly     Quarterly     Semi-Annually     Annually

Applicant Name \_\_\_\_\_

**PART ONE** (continued)

**Section D: Medicare Claim Number**

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

Your Medicare Claim No. - Part A Effective Date: \_\_\_\_/ **01** / \_\_\_\_

**Section E: Consumer Protection Information**

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? 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

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 **yes**, with what company, and what plan do you have? \_\_\_\_\_

b. If **yes**, do you intend to replace your current Medicare Supplement or Medicare Advantage 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**PART ONE** (continued)

**Section F: 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.***

If you answer “yes” to questions 1-8 below, and if you are applying before the 63rd day after your coverage terminated, you are eligible for guarantee issuance of this Medicare Supplement policy. Please place an “X” in the box next to the Guarantee Issue statement for which you qualify. Please proceed to page 7. Read the representations, acknowledgements and authorizations. Sign the application. Your application is complete and ready to be submitted.

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.
  
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 were 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.
  
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.

**PART ONE – Section F (continued)**

- 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.
  
- 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).
  
- 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.
  
- 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.
  
- 8. The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

**PART TWO: Health History/Medical Questions**



**Note: Anyone in Open Enrollment or if you have determined that you are eligible for Guaranteed Issue based on SECTION F, “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. 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

**PART TWO** (continued)

4. 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:
- 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)? 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
  - 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 5 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 for 14 or more days? Yes  No
8. 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
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** \_\_\_\_\_

## **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 Texas, which is herein called the Company. If choosing Medicare Select, I have also read and understand the statements regarding Medicare Select as described in the enclosed Outline of Coverage. 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.\*

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).

\* 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.

Applicant Name \_\_\_\_\_

**PART THREE** (continued)

I hereby apply for coverage and request an inspection policy for the Medicare Supplement policy indicated. 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.

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. If I falsify or fail to include all material information (e.g. age and medical history) required on this application, my policy will be rescinded by the Company. Rescission means voiding my policy back to its effective date. If my policy is rescinded, any premiums paid (less any benefits paid) will be refunded.

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.

**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 1-888-731-0415,  
call your insurance agent at the number listed on the next page,  
or visit [www.bcbstx.com](http://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 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: \_\_\_\_/\_\_\_\_/\_\_\_\_

**PART THREE** *(continued)*

**Agent Information** *(If Applicable)*

*The following statements apply if you are purchasing coverage through an agent:*

- The undersigned acknowledges that any agent is acting on his/her 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.
- The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, he/she should contact the agent.
- The applicant(s) have received a copy(s) of the Medicare Supplement Buyers Guide.

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

\_\_\_\_\_

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.

**Signature:** **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print name: \_\_\_\_\_ Texas Broker Code: \_\_\_\_\_

Agency name *(If Applicable)*: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_