BlueCross BlueShield of Texas

Application for Medicare Supplement Insurance Plan*

1. Have your Medicare card and Social Security card available to fill in the required information below.

2. **Complete and sign the application in ink**, then mail it in the enclosed postage-paid envelope. **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.

For coverage to go into effect, you must be under age 65, reside in Texas and have Medicare Parts A and B. You must also apply within six (6) months of your Medicare Part B effective date, or qualify as an Eligible Person as defined in the Supplement to this Application. If you meet these conditions, Plan A is Guaranteed Issue.

A. Plan Selection

I would like to apply for: ☑ **Plan A**

See the enclosed Outline of Coverage for rate information.

Make policy effective: ☐☐/☐☐/☐☐☐☐
Month Day Year

B. Personal Information

Name _____

Address _____

City _____ County _____

State _____ ZIP _____

Male ☐ Female ☐

Your Birthdate ☐☐/☐☐/☐☐☐☐
Month Day Year

Your Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐

Blue Cross and Blue Shield of Texas, P.O. Box 660717, Dallas, Texas 75266-0717

* **Not connected with or endorsed by the U.S. Government or Federal Medicare Program.**

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

C. Medicare Beneficiary Identifier

Please see your Medicare card for this information.

Copy the Medicare Beneficiary Identifier from your red, white and blue Medicare card. This number must be provided for us to complete your application process.

Medicare Beneficiary Identifier

☐☐☐☐☐☐☐☐☐☐☐

Your Medicare Part A effective date:

☐☐/**0**☐/☐☐☐☐

Month *Day* *Year*

D. 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 insurance 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 insurance policy? . . . . . ☐ Yes ☐ No

b. Was this your first time in this type of Medicare plan? . . . . . ☐ Yes ☐ No

c. Did you drop a Medicare Supplement insurance policy to enroll in the Medicare plan? . . . . . ☐ Yes ☐ No

5. Do you have another Medicare Supplement insurance policy 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 insurance policy 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 this plan, leave "END" blank.)

START: ☐☐/☐☐/☐☐☐☐

END: ☐☐/☐☐/☐☐☐☐

IMPORTANT INFORMATION REGARDING MEDICARE SUPPLEMENT COVERAGE

You do not need more than one Medicare Supplement insurance 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 insurance policy.

If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement insurance 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 insurance policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.* If you are eligible for, and have enrolled in a Medicare Supplement insurance 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 insurance 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 insurance policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement insurance 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.*

Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance plans 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).

Please sign the signature line below.

I hereby apply for coverage and request an inspection policy for the Medicare Supplement insurance policy indicated. I understand that once my first premium payment is received, I will be covered as of the date shown on my Blue Cross and Blue Shield of Texas 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, are to the best of my knowledge and belief, complete and true, and I agree that Blue Cross and Blue Shield of Texas believing them to be true shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.

I understand any Medicare Supplement insurance plan carrier is required to offer a minimum of Plan A to those who are under the age of 65 and Medicare eligible due to disability. In order to be eligible, I am applying for this coverage with Blue Cross and Blue Shield of Texas within six (6) months of my Medicare Part B effective date; or I qualify as an eligible person as defined in the Supplement to this application, and I am applying for coverage no later than 63 days after the termination of prior coverage. I agree to pay the premium rate established for this coverage.

Signature

Must be signed and dated to avoid delays in processing. I have read and understand the statements on the reverse side regarding Medicare Supplement coverage. I have received the appropriate Outline of Coverage.

Signature: **X**_____ Date: ☐☐/☐☐/☐☐☐☐

Primary Phone: ( )_____ Secondary Phone: ( )_____

E-Mail Address_____

* If the Medicare Supplement insurance 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.

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.

Agent Signature: **X** _____ Date: _____/_____/_____

Print name: _____ Broker Code: _____

Agency name *(If Applicable):* _____ Phone: _____

Questions?

Call us toll-free at

1-888-731-0415