



BlueCross BlueShield of Minnesota

An independent licensee of the Blue Cross and Blue Shield Association

MEDICARE SUPPLEMENT/MEDICARE SELECT PLAN Application for Coverage

How to complete this application:

1. You must have both Medicare Part A and Part B to qualify for this coverage. To use this application, your Medicare Part B effective date must be within six (6) months prior to the effective date of this application, or you must be eligible for guarantee issue of coverage. If past the six (6)-month Medicare Part B effective date and not eligible for guarantee issue, you must use an application which contains health history questions (form F8318). To determine if you qualify for guarantee issue, see the SPECIAL NOTES section in this application. Please include a copy of your Medicare ID card with this application.
2. Please print and use a ball point pen. Applications completed in pencil are not acceptable. Please answer all questions completely.
3. If you and your spouse both wish to apply, please complete separate applications.
4. **Payment method (Section I, item #10)—please include your first payment with this application.**
 - monthly Pay-O-Matic requires a one (1)-month payment
 - annual method requires a 12-month payment
 - semiannual method requires a six (6)-month payment
 - quarterly method requires a three (3)-month payment
5. Sign and date your application. Return the original to Blue Cross and Blue Shield of Minnesota (Blue Cross). Keep the copy for your records.
6. Please allow 30 calendar days for your coverage to be set up. You will receive your member identification card after your application has been processed.

These plans provide an anticipated loss ratio of 65%. This means that on the average, a contractholder may expect that at least \$65 of every \$100 in premium payments will be returned as benefits to the contractholder over the life of the contract.

Questions?

Call your local Blue Cross agent or one of our licensed marketing associates.
We are happy to help you.

(651) 662-5682
1-800-711-9874

ORIGINAL—Blue Cross and Blue Shield of Minnesota **COPY**—Applicant

SPECIAL NOTES

- **GUARANTEE ISSUE**—Medicare Supplement and Select issuers must guarantee issue certain Basic Medicare Supplement and Select policies to eligible individuals. This means that the insurer cannot discriminate in the pricing of such a policy because of health status, claims experience, receipt of care, medical condition or age. If you are currently enrolled in a Medicare Select, Medicare Supplement, Employer Retiree Plan, Medicare Advantage, Medicare Cost or Health Care Prepayment Plan and the contract is terminating, you may be eligible for guarantee issue. You must apply for coverage within 63 calendar days of the date your coverage terminates and include a copy of that plan's termination letter. If your Medicare Advantage plan is terminating, your eligibility for guarantee issue begins on the date you were notified of the termination. You must apply for coverage within 63 days from the date you were notified. If you apply for coverage after the guarantee issue enrollment period, you may need to complete an application which contains health history questions to be considered for coverage.
- **MULTIPLE COVERAGE**—You do not need more than one (1) Medicare Supplement/Medicare Select policy or certificate. If you purchase this policy, you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
- **DISABILITY**—If you are enrolled in Medicare because you are disabled and are covered under a group health plan through your employer, you may not need this Medicare Supplement or Select policy. The benefits and charges you receive under this Medicare Supplement or Select policy may be suspended during your enrollment in a group health plan. You must request this suspension in writing by contacting Blue Cross. When your group health plan coverage ends, your Medicare Supplement or Select policy will be reactivated if you request us to do so in writing within 90 days of your group plan coverage termination.
- **MEDICAID**—You may be eligible for benefits under Medicaid and may not need a Medicare Supplement/Medicare Select policy or certificate. The benefits and premiums under this Medicare Supplement/Medicare Select contract can be suspended, if requested, for a total of 24 months during your entitlement to benefits under Medicaid. You must request this suspension in writing within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, this contract may be reinstated. However, you must request reinstatement in writing within 90 days of losing Medicaid and your Medicare Supplement/Medicare Select policy must not have been suspended for more than 24 months.
- **COUNSELING SERVICES**—Insurance counseling services are available in Minnesota to provide advice concerning Medical Assistance through state Medicaid, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs) through the Minnesota State Health Insurance Assistance Line at 1-800-333-2433.

SECTION I

1. Name *Last* _____ *First* _____ *MI* _____ Gender M F

2. Home Address *Street* _____ *City* _____ *State* _____ *Zip* _____
MN

Phone () _____ *County* _____

Billing Address (if different) _____

3. Birth Date _____ 4. Social Security Number _____

5. Are you enrolled for coverage under Part A (Hospital) and Part B (Medical) of Medicare?
 Yes NO (If NO, you are not eligible for this coverage).

6. Please include a photocopy of your Medicare Health Insurance Card or your Letter of Verification from the Social Security Administration or Railroad Retirement Board. We must verify your Medicare coverage. Without it, your application will be returned to you.

Health Insurance SOCIAL SECURITY ACT			
Name of Beneficiary			
John Doe			
Claim Number			Gender
x x x	: x	x x x x	x m
Is Entitled to: (Effective Date) Month Day Year			
Hospital Insurance		0, 0	0, 0 0, 0
Medical Insurance		0, 0	0, 0 0, 0

7. Marital Status
 Single
 Married
 Widowed

8. Select Only One (1) Plan
 Basic Medicare Select (Senior Gold), plus:
 Preventive care coverage
 Basic Medicare Supplement (Basic Medicare Blue), plus (you may choose any combination of the following optional coverages):
 Preventive care coverage
 Coverage of Medicare Part A inpatient hospital deductible
 Coverage of Medicare Part B annual deductible
 Coverage of 100% of eligible medical expenses and supplies not covered by Medicare Part B that exceed Medicare approved charges
 Extended Basic Medicare Supplement (Extended Basic Blue)

9. Amount paid with this application \$ _____ 10. Payment Method Pay-O-Matic (monthly) Semiannually
 Quarterly Annually

11. Tobacco Use Designation and Declaration

I have used tobacco and/or smokeless tobacco during the 24 months immediately preceding the date of this application. Yes No

(Please note that your rates may be modified if you indicate that you do not use tobacco as of the effective date of this application and evidence to the contrary is later discovered. If you are tobacco-free for a 24 consecutive-month period after your effective date, you must notify Blue Cross and Blue Shield of Minnesota, in writing, so that your rate can be decreased).

12. I agree that, if approved, coverage will be effective on the first day of the month following approval or on the date designated here, provided it is not prior to the date this application was received at Blue Cross and is not more than 60 days beyond the date this application is signed.

Requested Effective Date: _____

FOR AGENT USE ONLY

Agency Code _____ Agent's Number _____

Agent's Name _____

SECTION III

1. I acknowledge receipt of the *following information*:

- **Summary of Coverage and Disclosure of Information form** Yes No
- **Blue Cross Blue Shield of Minnesota Insurance Suitability form** Yes No
- **Guide To Health Insurance For People With Medicare** Yes No

(If NO, please contact your agent)

By the signature below, I acknowledge that all of the statements made on this application are true and complete to the best of my knowledge.

By the signature below, I hereby authorize and request any hospital, clinic, institution, physician, or other person to furnish Blue Cross full details of diagnosis, treatment, medical history, and any other information and conclusions about me and to accept as valid a photocopy of this authorization and my signature. We need this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. We keep this information confidential, but may release it if you authorize release, or if state or federal law permits or requires release without authorization. For claims purposes, this release is valid while you are enrolled in this health plan and until all claims are adjudicated after your termination of coverage. You are entitled to receive a copy of this release.

Your Signature X _____

Date _____ **Daytime Phone No.** (_____) _____

If an agent has recorded the responses given by the applicant, please sign below.

Agent's Signature X _____

Date _____ **Daytime Phone No.** (_____) _____

2. Agents shall list any other health insurance policies they have sold to the applicant.

3. Have you remembered to:

- **Sign your application?**
- **Submit your first payment?**
- **Enclose a copy of your Medicare card?**
- **Complete a Pay-O-Matic form and include a voided check?**
- **Indicate when you want your coverage to begin?**
- **Keep a copy of this application for your records?**
- **Mail this application to:**

**Blue Cross and Blue Shield of Minnesota
P.O. Box 64560
St. Paul, Minnesota 55164-0560**

Your application cannot be accepted without your signature.

**BLUE CROSS AND BLUE SHIELD OF MINNESOTA
SERVICE CENTERS**

DULUTH

405 West Superior St.

Duluth, MN 55802

(218) 722-3371

(800) 232-1383

TTY (888) 878-0137

TWIN CITIES

P.O. Box 64560

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(651) 662-5682

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