

Medicare Supplement Application

APPLICANT INFORMATION

Your Name (first, middle initial, last)		Date of Birth	Age	<input type="checkbox"/> Male <input type="checkbox"/> Female
Physical Address (street or route)		City, State, Zip Code		County
Mailing Address (if different than physical address)		City, State, Zip Code		County
Billing Address (if different from physical address)		City, State, Zip Code		County
Social Security Number	Preferred Phone		Alternate Phone	
Email Address (Optional)*		Medicare Number		
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married		Do you now or have you ever smoked or used tobacco in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you have Part A of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____		Do you have Part B of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____		

*By providing us with your email address you are agreeing to receive communications regarding your plan benefits and well-being. You can opt out at any time.

CONFIRM THE PLAN YOU ARE APPLYING FOR BY CHECKING THE BOX BELOW:

- ☐ MedPlus – Plan A ☐ MedPlus – Plan F (For those eligible for Medicare prior to January 1, 2020)
☐ MedPlus – Plan G ☐ MedPlus – Plan G, High Deductible

Requested Effective Date: _____

The effective date on the policy will be the first of the month following receipt and acceptance of the application by Blue Cross of Idaho Care Plus, Inc. or the requested effective date, whichever comes later.

You may be eligible for a lower premium if another person that currently has a Blue Cross of Idaho Medicare Supplement plan resides at the same address.

- ☐ I live with a person who's currently covered under a Blue Cross of Idaho Medicare Supplement plan.

Name of Covered Person: _____ Enrollee ID Number: _____

- ☐ I live with a person who is in the process of applying for a Blue Cross of Idaho Medicare Supplement plan.

Name of Covered Person: _____ Enrollee ID Number: _____

- ☐ I do not currently live with another person who has a Blue Cross of Idaho Medicare Supplement plan, and am not eligible for the household discount.

IMPORTANT INFORMATION BEFORE YOU APPLY

You do not need more than one (1) Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. 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 twenty-four (24) months. You must request this suspension within ninety (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 ninety (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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. 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 ninety (90) days of losing your employer or union-based 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. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), 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).

OTHER COVERAGE 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.

To the best of your knowledge:

1. (a) Did you turn 65 in the last six (6) months? ☐ Yes ☐ No
(b) Did you enroll in Medicare Part B in the last six (6) months? ☐ Yes ☐ No
(c) If **YES**, what is the effective date?
2. 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.

If **YES**:

- (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
- (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No
3. (a) Did you have coverage from any Medicare plan other than original Medicare within the past sixty-three (63) days (for example, a Medicare Advantage Plan, or a Medicare HMO or PPO)?
(i) If so, with what company and what kind of policy? _____
(ii) What are your dates of coverage under the other policy? _____
(iii) List the full member ID number as printed on your member ID card. _____
(b) 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
(c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
(d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
4. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
(b) If so, with what company? _____ What plan do you have? _____
(c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
5. Have you had coverage under any other health insurance within the past sixty-three (63) days (for example, with an employer, union, or individual plan)? ☐ Yes ☐ No
(a) If so, with what company and what kind of policy? _____
(b) What are your dates of coverage under the other policy? _____
(c) List the full member ID number as printed on your member ID card. _____

HEALTH STATEMENT

Please disregard if you are applying during Medicare initial enrollment period (within six months of your plan B effective date) or have federal/state guarantee issue rights.

Height_____ Weight_____

Answer each question Yes or No. If **YES**, in the chart below, write the item number along with specific condition details.

Has the applicant had or been told he or she has any of the following within the past five years:

1. Cancer, cyst or tumor (malignant or benign)? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Parkinson's, Multiple Sclerosis (MS) or Amyotrophic Lateral Sclerosis (ALS)? <input type="checkbox"/> Yes <input type="checkbox"/> No
2. Heart trouble, chest pain, stroke, hemophilia or any other disorder of the blood or circulatory system? <input type="checkbox"/> Yes <input type="checkbox"/> No	9. Emphysema, tuberculosis (TB) or removal of any part of the lung? <input type="checkbox"/> Yes <input type="checkbox"/> No
3. High blood pressure or heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No	10. Rheumatoid arthritis or osteoarthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No
4. End-stage renal disease, dialysis, chronic hepatitis, cirrhosis or any other disorder of the kidney, liver or intestines? <input type="checkbox"/> Yes <input type="checkbox"/> No	11. HIV infection or AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No
5. Diabetes or thyroid disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	12. Amputations or prosthetic devices? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Epilepsy, convulsions, Alzheimer's disease, dementia, loss of consciousness or any other cognitive disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	13. Any illness, condition or irregular symptoms not named above? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Organ transplant or any disorder of the stomach, bladder or prostate? <input type="checkbox"/> Yes <input type="checkbox"/> No	14. Advised to have surgery or hospitalization that has not yet been performed? <input type="checkbox"/> Yes <input type="checkbox"/> No

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If you answered **YES** to any question above, please explain below. Use extra paper if needed.

Item No.	Diagnosis	Type of Treatment	Date of Illness	Date of Last Visit	Was Recovery Complete?
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

List any medications or drugs taken by applicant within the past 12 months. Use extra paper if needed.

Item No.	Medication Name (Dosage)	Condition Requiring Medication	Still Taking?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

STATEMENT OF UNDERSTANDING

- I understand and agree that the statements and answers on this Application and Health Statement are complete and accurate, and that any false statement, misrepresentation or concealment of fact may, at the option of Blue Cross of Idaho Care Plus, bar recovery of any benefits, and shall be grounds for voidance or cancellation of the policy.
- I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating healthcare treatment, payment or for the purpose of business operations necessary to administer healthcare benefits, or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Care Plus Notice of Privacy Practices that is available at **medicare.bcidaho.com**.
- I understand and agree that the deposit, \$_____ (if any), submitted with the Application is not binding upon Blue Cross of Idaho Care Plus for the benefits applied for herein until the application is approved; after approval, the deposit then is payment of premiums for _____ month(s) from the effective date.

The Notice to Applicant and Outline of Coverage were furnished to me on _____ (Date).

Applicant's Signature _____ Date _____

Independent Producer (agent) Certification

1. Who actually completed this application? ☐ Applicant ☐ Independent Producer ☐ Other
If Independent Producer or Other, please explain: _____
 2. Were you present at the time the application was filled out? ☐ YES ☐ NO
If **NO**, please explain: _____
 3. Are you aware of any medical information relating to the applicant or any family member that has not been disclosed on this application? ☐ YES ☐ NO
If **YES**, please explain: _____
 4. Was money collected from the applicant? ☐ YES ☐ NO Amount \$_____
 5. (a) List policies you have sold the applicant which are still in force (use extra paper if needed)

 - (b) List policies you have sold to the applicant in the past five (5) years which are no longer in force (use extra paper if needed)

- I hereby certify that I personally solicited and completed this application, that I personally asked each question on this application, and have accurately recorded the answers.
 - That the answers to all of the questions are complete and accurate to the best of my knowledge and belief.
 - That I have explained the eligibility provisions to the applicant and have not made any representations about benefits, conditions or limitations of the policy, except through written material furnished by Blue Cross of Idaho Care Plus.
 - That I have verified the dates on the applicant's member ID card.
 - I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.
- Type of Company Appointment: ☐ Personal ☐ Agency (Name) _____

Agent's Name_____
ID Number_____
Signature of Agent_____
Date

Medicare Supplement plans are offered by Blue Cross of Idaho Care Plus, Inc. When this document says Blue Cross of Idaho Care Plus, it means Blue Cross of Idaho Care Plus, Inc.

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