

APPLICATION FOR SUPPLEMENT TO MEDICARE

You must have both Medicare Part A and Part B to apply for these plans.

<p>1800 Ninth Avenue P.O. Box 91053 Seattle, Washington 98111-9153 206 464-3804 • 1 888 344-8234</p> <p><small>An Independent Licensee of the Blue Cross and Blue Shield Association</small></p>	<p>MAIL APPLICATION TO: PO Box 1107 1602 21st Ave. Lewiston, ID 83501</p>
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PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM.

- You do not need more than one Medicare supplement contract.
- If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement contract.
- If, after purchasing this contract, you become eligible for Medicaid, the benefits and rates under your Medicare supplement contract can be suspended, if requested during your entitlement to benefits under Medicaid for up to 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 contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing your Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract 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 contract by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and rates under your Medicare supplement contract can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement contract under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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).

PLEASE PRINT. Answer all questions completely and accurately to ensure timely processing.

Name	Birth Date	Age	Social Security Number
Address			
Billing Address (if different)			
Telephone	<input type="checkbox"/> Male		<input type="checkbox"/> Female

Coverage Applied For:

- | | | |
|---|--|---|
| <input type="checkbox"/> A – Base Plan | <input type="checkbox"/> C - Cascade Plan | <input type="checkbox"/> F - Vista Plan |
| <input type="checkbox"/> A – Base Plan for under age 65 disabled | <input type="checkbox"/> E - Alpine Plan | <input type="checkbox"/> J - Discover Plan |

_____	_____	_____
<small>Agent #</small>	<small>Package #</small>	<small>Effective Date</small>

Please copy the information from your Medicare card onto the sample card at right, or attach a copy of your Medicare card, or the Letter of Verification from the Social Security Administration or Railroad Retirement Board. **This information is required to process your application.**

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY _____	
MEDICARE CLAIM NUMBER _____	SEX _____
IS ENTITLED TO: _____ EFFECTIVE DATE _____	
HOSPITAL (PART A) _____	
MEDICAL (PART B) _____	

TYPE OF BILLING DESIRED

- Automatic Bank Withdrawal *(Complete the Subscriber Agreement for Preauthorized Bill Payment form)*
- Standard Billing/Payment by Check *(Indicate desired billing schedule below.)*
 - Monthly
 - Quarterly
 - Semiannually
 - Annually

TYPE OF APPLICATION

- New
- Transferring from another Blue Shield plan.
 - Name of Plan _____
- Converting from a Regence BlueShield group plan.
- Converting from another company.
 - Name of Company _____
 - Name/type of Policy _____
- Converting from a Regence BlueShield individual plan.

Complete this section only if you are transferring from a Regence BlueShield individual plan.

I request cancellation of Regence BlueShield individual plan coverage.

By authorized signature below, the applicant agrees to the following:

I understand that the benefits provided by Medicare and a Medicare Supplement plan may duplicate those benefits covered under my current Regence BlueShield individual health plan. If accepted for a Medicare Supplement plan, I authorize Regence BlueShield to cancel my current Regence BlueShield individual health plan coverage when my Medicare Supplement coverage begins.

APPLICANT SIGNATURE: _____ **DATE** _____

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.

Authorization signature required on Page 7.

**PLEASE ANSWER ALL QUESTIONS (please mark Yes or No with an "X").
TO THE BEST OF YOUR KNOWLEDGE...**

Yes No

- (a) Did you turn age 65 in the last 6 months?
- (b) Did you enroll in Medicare Part B in the last 6 months?
- (c) If Yes: what is the effective date? _____
- Are you covered for medical assistance through the state Medicaid program?
(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 rates for this Medicare supplement contract?
 Yes No
- (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
 Yes No

(a) 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 below. If you are still covered under this plan, leave "END" blank.

START / / END / /

(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?

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

Do you have another Medicare supplement policy in force?

If Yes: a. With which company and what plan do you have? _____

If Yes: b. Do you intend to replace your current Medicare supplement policy with this contract? Yes No

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

If Yes: a. With which company? _____

b. What kind of policy? _____

What are your dates of coverage under the other policy?

START / / END / /

(If you are still covered under the other policy, leave "END" blank.)

Authorization signature required on Page 7.

HEALTH STATEMENT REQUIREMENTS

Completion of the following Health Statement is not required for every applicant. Please read the following information carefully to determine if you are required to complete it.

It is **not necessary to complete the health statement if you are:**

- ◆ Applying within six months of your first enrollment under Medicare Part B; or
- ◆ Applying within six months of turning age 65; or

◆ *Transferring from:*

Plan A
Plans B, C, D, E, F, G, H, I, J, or other more comprehensive plan
Medicare Advantage plan



Transferring to:

Regence Base Plan (A)*
Regence Base Plan (A)* Regence Cascade Plan (C) Regence Alpine Plan (E) Regence Vista Plan (F) Regence Discover Plan (J)
You may not be eligible for all plans. Please contact us for details.

****The Base Plan is the only plan available for disabled persons under age 65.***

PLEASE COMPLETE THE HEALTH STATEMENT IF NONE OF THE ABOVE SITUATIONS APPLIES TO YOU.

HEALTH STATEMENT

Washington State law requires that the health statement be completed by the applicant or the applicant's relative, legal guardian, or physician.

Please indicate whether or not you have received treatment for any of the following conditions within the last **five** years. Each condition must be checked yes or no.

Yes	No	Condition	Yes	No	Condition
<input type="checkbox"/>	<input type="checkbox"/>	1. AIDS or HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	12. Vein or artery disease
<input type="checkbox"/>	<input type="checkbox"/>	2. Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	13. Heart disease
<input type="checkbox"/>	<input type="checkbox"/>	3. Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	14. High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	4. Alzheimer's Disease	<input type="checkbox"/>	<input type="checkbox"/>	15. Intestinal problems
<input type="checkbox"/>	<input type="checkbox"/>	5. Back trouble	<input type="checkbox"/>	<input type="checkbox"/>	16. Kidney/bladder problems
<input type="checkbox"/>	<input type="checkbox"/>	6. Cancer, Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	17. Liver problems
<input type="checkbox"/>	<input type="checkbox"/>	7. Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	18. Parkinson's Disease
<input type="checkbox"/>	<input type="checkbox"/>	8. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	19. Prostate disorders
<input type="checkbox"/>	<input type="checkbox"/>	9. Emphysema/lung disorders	<input type="checkbox"/>	<input type="checkbox"/>	20. Psychiatric care
<input type="checkbox"/>	<input type="checkbox"/>	10. Gall bladder problems	<input type="checkbox"/>	<input type="checkbox"/>	21. Stroke
<input type="checkbox"/>	<input type="checkbox"/>	11. Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you been hospitalized or had surgery in the past five years?

Authorization signature required on Page 7.

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to *Regence BlueShield* (“*Regence*”) or its representatives my health information (including alcohol, chemical dependency, mental health treatment, genetic testing, or HIV treatment). I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). I understand that any charge for obtaining the information will be my responsibility.

If I choose to not sign this authorization, Regence may be unable to enroll me in the health plan or to pay claims that were incurred while I had insurance coverage with Regence.

I may cancel this authorization at any time by sending a written request to Regence. My cancellation of this authorization will not affect any action Regence took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with Regence or 24 months from the date below, whichever comes first.

Federal Law requires Regence to tell me that if the party to whom Regence discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR part 2). Federal law prohibits redisclosure of this information without specific written authorization.

Please sign and date on Page 7.

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES.

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversations during a counseling session.)

AUTHORIZATION SIGNATURE

I understand that a true copy of this application will be attached to my contract when it is issued.

I have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. For the protection of all of our members, knowingly providing us with false, incomplete or misleading information may result in Regence BlueShield taking any action allowed by law or Contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties.

I hereby authorize the Centers for Medicare and Medicaid Services (Medicare) to release to Regence BlueShield any information from Title XVIII (Medicare) that is required to process my claims in conjunction with Medicare, if applicable; additionally, Regence BlueShield may release such information about me to properly coordinate benefits with processors of Medicare claims. This authorization is ongoing for as long as I am or will be eligible for Medicare and remain enrolled in this plan.

I acknowledge that I have received a copy of the following (check all that apply):

- Choosing a Medigap Policy
- Notice of Replacement Coverage
- Outline of Coverage

Please sign and date on next page.

Authorization signature required on Page 7.

APPLICANT SIGNATURE:* _____ **DATE** _____

*If signature by a personal representative of the subscriber/enrollee, please complete the following:

Personal Representative's Name: _____

Relationship to Individual: Parent Legal Guardian† Holder of Power of Attorney†

†Attach legal documentation if Legal Guardian or Holder of Power of Attorney.

Requested Effective Date: _____

HOW DID YOU HEAR ABOUT REGENCE BLUESHIELD?

Please check the box that best describes how you heard about Regence BlueShield.

Regence Group Plan Regence Individual Plan Web site Seminar Agent

Radio Television Newspaper Direct mail Word of mouth

Other: _____

If you have an agent, that agent may receive commissions from Regence BlueShield. Commissions are paid at the same flat rate for the life of the consumer, as long as the policy remains in effect. These commissions may have an indirect impact on your rates. For more information, please contact your agent.

AGENT INFORMATION

If application is being made through an agent, he or she must complete the following and the Notice of Replacement included with this application, if appropriate. If all information is not completed, the application will be returned.

1. List any other medical or health insurance policies sold to the applicant: _____

2. List policies that are still in force: _____

3. List policies sold in the past five years that are no longer in force: _____

Agent Name	Agent Number
I certify, to the best of my knowledge, that the applicant has truthfully completed the application and all health problems are listed. I further certify that I have verified that the person applying for coverage is eligible for Parts A and B of Medicare.	
_____	_____
Agent/Signature	Date

Authorization signature required on Page 7.