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

(Individual)
F8317 (9/05)

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 may 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*

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 – x m
SAMPLE
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) ❒ Quarterly ❒ Semi-annually ❒ Annually

11. **Tobacco Use Designation and Declaration**
I have used tobacco and/or smokeless tobacco during the 36 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 36 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 II—Please answer these questions to the best of your knowledge

1. **Do you have any other Medicare Supplement/Medicare Select policies or certificates?**

   ❒ Yes ❒ No

2. **Do you have any other health insurance policies with Blue Cross and Blue Shield of Minnesota, or another carrier, that provide benefits that this Medicare Supplement/Medicare Select contract would duplicate? ❒ Yes ❒ No**

   If you answered yes to either of the above questions, do you intend to replace any of your medical or health insurance coverages with this contract? **❒ Yes ❒ No**

3. **Are you being terminated from a Medicare Select, Medicare Supplement, Employer Retiree Plan, Medicare Advantage, Medicare Cost or Health Care Prepayment plan?**

   ❒ Yes ❒ No

   If yes, you may be eligible for the guaranteed issuance of a Medicare Select or Supplement contract. Please include a copy of your current plan's termination letter and read the SPECIAL NOTES section, in this application, about guarantee issue, or ask your agent to help you determine whether or not you need to complete a health history application.

4. **If you answered yes to questions 1, 2 or 3 in this section, please provide us with the following information about your current plan:**

   Company Name________________________ Company Phone Number____________

   Type of Policy________________________ Policy Number ________________

   Effective Date________________________ Termination Date ______________

   If your current coverage is with Blue Cross and Blue Shield of Minnesota or Blue Plus, may we contact your employer to coordinate your Medicare Supplement effective date?

   ❒ Yes ❒ No

   If your spouse is currently covered under your Blue Cross and Blue Shield of Minnesota or Blue Plus contract and will continue that coverage, complete the following:

   Spouse's Name____

   Spouse's Birthdate____________________ Social Security Number ______________

5. **Are you covered by Medical Assistance through the state Medicaid program? ❒ Yes ❒ No**

   If yes, which of the following programs provides coverage for you?

   ❒ Qualified Medicare Beneficiary (QMB)

   ❒ Full Medicaid Beneficiary

   ❒ Specified Low-Income Medicare Beneficiary (SLMB)

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. (** 612 **)** 991-3546

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

TWIN CITIES
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