BlueCross BlueShield of Texas

Home Office Use Only

Application for Medicare Supplement Insurance Plan

Instructions

1. Have your Medicare and Social Security cards handy 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 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.

Plan Selection

☑ **Plan A**

Requested Policy Effective Date: ____/____/____

See the enclosed Outline of Coverage for rate information.

Applicant Information

Name (First)	(Middle)	(Last)	
Home Address (No P.O. Boxes)	City	State **TX**	ZIP
Age	Date of Birth / /	Gender ☐ Male ☐ Female	
Social Security Number			

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association
Blue Medicare Supplement | c/o Member Services | PO Box 3388 | Scranton, PA 18505

Applicant Name: _____

Household Discount

You may be eligible for a household discount if at least two members reside in the same household and are enrolled in a BCBSTX Medicare Supplement Insurance Plan effective on or after January 1, 2020.

Are you eligible for the household discount?	☐ Yes	☐ No

If yes, provide a qualifying household member's information (optional):

Name (First)	(Last)	Policy Number

Medicare Beneficiary Identifier

Please copy the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Medicare Beneficiary Identifier ☐☐☐☐☐☐☐☐☐☐☐

Part A Effective Date: /

Applicant Name: _____

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?	Effective Date:	
3. 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.*	☐ Yes	☐ No
a. If yes, will Medicaid pay your premiums for this Medicare Supplement 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 Date" blank.)*	Start Date:	End Date:
a. 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
b. Was this your first time in this type of Medicare plan?	☐ Yes	☐ No
c. Did you drop a Medicare Advantage policy to enroll in the Medicare plan?	☐ Yes	☐ No
5. Do you have another Medicare Supplement policy in force?	☐ Yes	☐ No
a. If so, with what company, and what plan do you have? _____		
b. If so, do you intend to replace your current Medicare Supplement policy with this 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 the other policy, leave "End Date" blank.)*	Start Date:	End Date:

Applicant Name: _____

Statements

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

2. 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.

3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

4. 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 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 policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility.*

5. 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 90 days of losing your employer or union-based group health plan.*

6. Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Plan 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 Plans, call 1-800-MEDICARE (1-800-633-4227).

* 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.

Questions?

Call us at our Customer Service toll-free number **877-384-9307**,
call your insurance agent at the number listed on the next page,or visit **www.bcbstx.com**.

Applicant Name: _____

Acknowledgements and Signature

1. I hereby apply for coverage and request a policy to review for the Medicare Supplement policy indicated.

2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company 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.

3. I hereby declare that the statements and answers on this application, including but not limited to those relating to age, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.

4. 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 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.

5. I acknowledge that any agent is acting on my 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.

6. I acknowledge if I desire additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, I should contact the agent.

7. I acknowledge that I have received a copy of the Medicare Supplement Buyer's Guide.

8. ☐ **Outline of Coverage:** I acknowledge receipt of Outline of Coverage.

Signature Required

Must be signed **in ink** and dated to avoid processing delays. For Power of Attorney and Legal Guardianships, be sure to submit copies of the court documents with the application.

Applicant:	Date: / /
Primary Phone:	Secondary Phone:
Email Address:	

Applicant Name: _____

Agent Information (If Applicable)

The following information is to be filled out by an agent, if Applicant is purchasing coverage through an agent.

Please list any other health insurance policies or coverages sold to the applicant which are still in force:	
Please list 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:	Date: / /
Print Name:	Broker Code:
Agency Name (If Applicable):	Agent Phone: