MedigapSecurity

GROUP COVERAGE APPLICATION FORM

A TO APPLY FOR MEDIGAPSECURITY. . .

Please reference the enclosed MedigapSecurity Outline of Coverage for the monthly premium based on your plan.

Check the ONE plan for which you are enrolling:

☐ Plan A ☐ Plan B ☐ Plan C

Desired effective date: _____

LAST Name:	FIRST Name:	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms

Birth Date: ☐☐-☐☐-☐☐☐☐	Sex:	Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Permanent Residence Street Address:

City:	State:	ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Emergency Contact: _____

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Relationship to You:**

E-mail Address: _____

B PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join MedigapSecurity.

SAMPLE ONLY

Name: _____

Medicare Claim Number ☐☐☐☐☐☐☐☐☐☐ Sex _____

Is Entitled To Effective Date

HOSPITAL (Part A) ☐☐-☐☐-☐☐☐☐

MEDICAL (Part B) ☐☐-☐☐-☐☐☐☐

C DECLARATION

By signing the section J of the application, I elect coverage under the plan specified in section A of the form and for the persons listed there, and agree to abide by the conditions of the agreement and pay required premiums for the plan as selected. I hereby authorize any licensed physician, medical or medically related facility, insurance company, or other organization or person or institution that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and Highmark Blue Shield. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my Employer, Association, or Welfare board and Independence Blue Cross and Highmark Blue Shield.

D NOTICE REGARDING FRAUDULENT INFORMATION

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

E GENERAL INFORMATION

Various Medicare Secondary Payor (MSP) laws place responsibilities on certain employers that may affect the rights of employees, retirees, and/or their dependents who are eligible for Medicare. These MSP laws, in general, speak of certain persons who are age 65 or older, of certain persons who are disabled, and of certain persons who suffer from end-stage renal disease. If you have any questions about the MSP laws, please contact your employer.

F PLEASE ANSWER THE FOLLOWING QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. 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? ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)
3. 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, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
   Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No
4. Are you enrolled in PACE (Pennsylvania Pharmaceutical Assistance Contract for the Elderly)? ☐ Yes ☐ No
5. If you had coverage from any Medicare plan other than Original Medicare within the last 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 ☐☐-☐☐-☐☐☐☐ (MM DD YYYY) **END** ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

   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
   Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   Did you drop a Medicare supplement policy to enroll in the Medicare Plan? ☐ Yes ☐ No
6. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
   If yes, with what company and what plan do you have? _____
   If yes, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No
7. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan?) ☐ Yes ☐ No

   If yes, Insurance Company name: _____ Insurance Company ID #: _____

   Group #: _____ What kind of policy? _____

   Start Date: _____ End Date: _____

8. **To all Producers:** Producers shall list other health insurance policies they have sold to the applicant.

Following Policies are still in force: _____

Following Policies are not in force: _____

_____

Signature of Producer

G IMPORTANT — PLEASE READ CAREFULLY

You do not need more than one Medicare supplement policy.

If you purchase this policy, you may want to evaluate your existing health coverge 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 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 the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstituted if requested within 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 suspension.

H IMPORTANT — PLEASE READ CAREFULLY (CONTINUED)

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. 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 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).

I PLEASE READ AND SIGN BELOW

I hereby apply for the Policy coverage specified below. I understand that this application is subject to your acceptance and to the conditions and exclusions contained in the agreement. I agree to pay charges for these coverages as billed. I am covered by Medicare Part A and Part B.

I acknowledge and agree that any personally identifiable health information about me ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Independence Blue Cross and/or Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Independence Blue Cross and/or Highmark's Notice of Privacy Practices is available at www.site65.com.

I understand that the Independence Blue Cross/Highmark Blue Shield MedigapSecurity policy that I am applying for has a pre-existing condition provision. Under this provision, benefits related to any pre-existing condition will not be provided for six months after I enroll in MedigapSecurity. I also understand, however, that the pre-existing condition provision will not apply to these benefits if, when I enroll in MedigapSecurity, I have already satisfied a pre-existing condition provision for the benefits under another Medicare supplement policy or the pre-existing condition provision is waived because I am an "eligible person" as defined by federal and Pennsylvania laws and regulations.

If I was previously enrolled under another Blue Cross® and Blue Shield® policy or a Medicare supplement policy with another company with a pre-existing condition limitation, coverage under this policy for a pre-existing condition limitation will only be excluded to the extent of the time that I did not satisfy the pre-existing condition exclusion period under the previous policy and in no event shall such pre-existing condition exclusion exceed six (6) consecutive months from the effective date of my coverage under this policy.

"Pre-existing Condition" means a disease or physical condition for which medical advice or treatment has been received by me within one hundred eighty (180) days immediately prior to my initial effective date under this agreement or any endorsement made part of this policy.

I understand that I can find complete details of the program(s) in the Policy which I will receive after I return this Application Form.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this application and 2) documentation of this authority is available upon request by Independence Blue Cross and Highmark Blue Shield or by Medicare.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Benefits underwritten or administered by Independence Blue Cross and Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Your Signature: _____

Today's Date: ☐☐ - ☐☐ - ☐☐☐☐

FOR OFFICE USE ONLY		
IDENT. No.		
GR NO	TR DT	REAS
BC EFF	PR ST	ORIG
BS EFF	TC	

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: ☐☐☐ - ☐☐☐ - ☐☐☐☐ Relationship to Applicant: _____

1901 Market Street, Philadelphia PA 19103-1480

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

Independence Blue Cross
Highmark Blue Shield

Independence Blue Cross and Highmark Blue Shield are independent licensees of the Blue Cross and Blue Shield Association.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Independence Blue Cross
1901 Market Street
Philadelphia, PA 19103

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by Independence Blue Cross and Highmark Blue Shield. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premium.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has an outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:
  _____
  _____
- ☐ Other. (please specify)
  _____
  _____

Signature of producer or other representative (A signature is not required for direct response sales).

Typed Name and Address of issuer, producer or other representative

Applicant's Signature Date

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.