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BlueCross BlueShield of North Carolina
P.O. Box 25190
Durham, NC 27702

New Application for BlueMedicare Supplement℠

☐ New Enrollment ☐ Change Enrollment **Please fill in ALL information in blue or black ink.**

Section 1: Applicant Information

Questions? Call Toll-Free (800) 478-0583

Name must be exactly as it appears on your Original Medicare card:

First Name: Middle Initial:

Last Name: Suffix:

Birth Date (mm/dd/yyyy): Sex: ☐ Male ☐ Female Social Security Number: - -

Area Code: Telephone Number: - - Email Address:

Mailing Address (street):

City: State: Zip Code:

County:

Billing Address (if different from above – ONLY bills will be sent to this address)
(If this is a part of a list bill, please put entity's billing address below and fill out Section 3):

City: State: Zip Code:

County:

If you are a member under a Blue Cross and Blue Shield of North Carolina Certificate, provide your subscriber number:

Section 2: Plan Information

Choose the Plan you wish to select (check only one): ☐ A ☐ G ☐ High Ded G ☐ K ☐ N

When would you like your coverage to begin (mm/dd/yyyy):

/ /

IMPORTANT: This application is continued on the other side.

Section 3: Billing Information and Payment Authorization

You will be billed monthly.

I agree that the total premium will be billed, upon this application's acceptance, but not if this application is denied.

I agree that if charges are dishonored, whether with or without cause and whether intentionally or inadvertently, Blue Cross and Blue Shield of North Carolina (Blue Cross NC) shall have no liability whatsoever even though dishonor results in forfeiture of insurance.

If you are part of a list bill, please fill out the following:

Entity Name: _____ CORP #: M ☐☐☐

Section 4: Your Medicare Coverage

Please take out your red, white, and blue Medicare card to complete this section.

Fill out this information as it appears on your Medicare card.

Medicare Number: ☐☐☐☐☐☐☐☐☐☐☐

Effective Date (mm/dd/yyyy):

Hospital (Part A): ☐☐ / ☐☐ / ☐☐☐☐

Medical (Part B): ☐☐ / ☐☐ / ☐☐☐☐

Section 5: Consumer Information for Your Protection

You do not need more than one 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 will be suspended 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. 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 90 days of losing your employer or union-based group health plan.

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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 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).

Smoker rates do not apply during Guaranteed Issue period.

Section 6: Questions (Please Mark YES or NO Below with an "X")

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:

☐ Yes ☐ No 1. (a) Did you turn 65 in the last 6 months?

☐ Yes ☐ No (b) Did you enroll in Medicare Part B within the last 6 months?

If yes, what is the effective date (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

☐ Yes ☐ No 2. 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 **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 toward your Medicare Part B premium?

☐ Yes ☐ No 3. (a) If you had coverage from any Medicare Advantage plan, such as HMO or PPO within the past 63 days, fill in your effective and termination dates below:

Effective date (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Termination date (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

(If you are still covered under this plan, leave "Termination Date" blank.)

☐ Yes ☐ No (b) If you are still covered under the Medicare Advantage plan, do you intend to cancel your current coverage?

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☐ Yes ☐ No (c) Was this your first time in this type of Medicare Advantage 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?

(b) **If yes,** with what company and what plan do you have? _____

_____

☐ Yes ☐ No (c) **If yes,** do you intend to cancel your current Medicare supplement policy?

☐ Yes ☐ No 5. Have you had coverage under any health insurance within the past 63 days? (For example, an employer, union, or individual plan)

(a) **If yes,** please list with what company and your member ID: _____

_____

☐ Yes ☐ No (b) What are your dates of coverage with this other policy?

Effective date (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

Termination date (mm/dd/yyyy): ☐☐ / ☐☐ / ☐☐☐☐

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

Blue Cross NC may request a HIPAA certificate to verify coverage in the past 63 days.

☐ Yes ☐ No 6. Within the past 6 months, have you used tobacco regularly (4 or more times a week on average) excluding religious or ceremonial uses?

(a) **If yes**, when was the last time tobacco was used regularly? _____ (mm/dd/yyyy)

Note: Smoker rates do not apply during Guaranteed Issue Period.

Section 7: A Few Questions About Your Health

Completion of the following health questions is not required if you are applying for coverage within 6 months of first enrolling in Medicare Part B. If you meet these requirements, proceed to Section 8.

1. Have you been diagnosed, received treatment, or advised that you require treatment for the following conditions or diseases within the past 24 months?

☐ Yes ☐ No (a) Internal cancer, melanoma or lymphoma?

☐ Yes
☐ No

(b) Heart, circulatory or lung disease such as: cardiomyopathy, congestive heart failure, heart attack, coronary artery disease, peripheral artery disease, bypass surgery, aneurysm, atrial fibrillation, stroke, transient ischemic attack, chronic obstructive pulmonary disease, emphysema, any chronic pulmonary disease, require use of oxygen?

☐ Yes
☐ No

(c) Alzheimer's disease, dementia, Parkinson's disease, multiple sclerosis, muscular dystrophy, amyotrophic lateral sclerosis (Lou Gehrig's disease), systemic lupus erythematosus (SLE), scleroderma, myasthenia gravis?

☐ Yes
☐ No

(d) Organ transplant or been advised to have an organ transplant?

☐ Yes
☐ No

(e) Chronic liver disease, cirrhosis, chronic hepatitis?

☐ Yes
☐ No

(f) Chronic kidney disease, kidney failure, end stage renal disease (ESRD), require dialysis?

☐ Yes
☐ No

(g) Diabetes with complications such as: circulatory, amputations, retinopathy, neuropathy?

☐ Yes
☐ No

(h) Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC)?

☐ Yes
☐ No

(i) Back or spine disorder, degenerative bone disease, rheumatoid arthritis, psoriatic arthritis, joint replacement?

☐ Yes
☐ No

(j) Mental or nervous disorder requiring hospitalization?

☐ Yes
☐ No

(k) Alcohol or drug abuse?

☐ Yes
☐ No

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2. Are you currently hospitalized, residing in a nursing home, enrolled in a Hospice program, or expecting to enter a hospital or nursing home within the next 6 months?

☐ Yes
☐ No

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3. Have you been hospitalized more than once during the past 12 months?

☐ Yes
☐ No

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4. Are you confined to a wheelchair or motorized mobility device, or receiving occupational, speech or physical therapy?

☐ Yes
☐ No

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Section 8: By Signing Below, I Understand and Agree to the Following:

I hereby certify that all statements on this application are complete and true. Failure to provide complete and accurate information will allow Blue Cross and Blue Shield of North Carolina to deny future claims and seek a refund for claims paid as though the certificate had never been issued. I understand and agree that the certificate applied for will be effective only if the application is approved and a membership certificate is issued by Blue Cross and Blue Shield of North Carolina and fees have been paid. I understand that any coverage provided based on this application shall be subject to the provisions of the certificate and endorsements issued to me by Blue Cross and Blue Shield of North Carolina. (For information regarding waiting periods and pre-existing conditions, please refer to your "Outline of Medicare Supplement Coverage" booklet.)

I understand that if I am currently enrolled with Blue Cross NC on an individual policy (such as Blue Advantage®, Blue Advantage® Saver℠, Blue Options® HSA℠, Blue Value℠, Blue Home℠ or Blue Local℠), my policy will be canceled to correspond with the effective date of your Medicare Supplement coverage. This does not apply if your policy was purchased on the Health Insurance Marketplace. You will need to contact them directly in order for your policy to be terminated if you choose.

Signature of Applicant: _____

Date: ☐☐ / ☐☐ / ☐☐☐☐ (mm/dd/yyyy)

Note: This application cannot be processed without the applicant's signature.

Caution: Policy benefits are limited to those approved by Medicare for payment.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) provides free aids to service people with disabilities as well as free language services for people whose primary language is not English. Please contact the Customer Service number on the back of your ID card for assistance.

Blue Cross and Blue Shield of North Carolina (Blue Cross NC) proporciona asistencia gratuita a las personas con discapacidades, así como servicios lingüísticos gratuitos para las personas cuyo idioma principal no es el inglés. Comuníquese con el número para servicio al cliente que aparece en el reverso de su tarjeta del seguro para obtener ayuda.