Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MyBlue Medigap℠ Application for Coverage

Print in black or blue ink or type your information. This form can be completed by an insurance agent authorized to sell Blue Care Network policies, or you can fill it in yourself. You may also apply online at **https://bcn.destinationrx.com/PlanCompare/Consumer/type2/2014/Enroll/EnrollSelect.** You must complete all sections. Information indicated with an asterisk (*) is required for processing. Review your application for completeness and accuracy, and sign and date where requested. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be viewed online at **www.bcbsm.com.**

Step 1: Choosing your plan option

Choose your MyBlue Medigap plan option (check one)*

Plan option: ☐ **Plan A** ☐ **Plan F** ☐ **Plan N**

Please indicate how you want us to bill you (check one)* **DO NOT SEND PAYMENT WITH THIS APPLICATION**

☐ **Automatic deduction from your bank account** (check one choice below, and complete the Automatic Payment Plan form and send it to us along with this application):

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ **Send me a bill in the mail**. I want to pay my premium (check one):

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Month requested for coverage to start: _____ ***Note: Unless otherwise indicated, coverage always begins the first day of the month following receipt of your completed application.***

Step 2: Information about you

Last name*	**First name***	**M.I.***	**Suffix (if applicable)** ☐ Sr. ☐ Jr. ☐ Other _____

Street address*	**City***	**State** MICHIGAN	**ZIP***

Primary phone*	**Secondary phone**	**Applicant's email** *(You may receive emails about benefits, wellness and other health topics.)*
( ) _____–_____	( ) _____–_____	_____

Date of birth*	**Gender***	**Weight***	**Height***	**Have you used any form of tobacco in the past 12 months?***
____ / ____ / 19____	☐ Male ☐ Female	_____ pounds	____ feet ___ inches	☐ Yes ☐ No

If you are submitting your application within 6 months after you first enrolled for benefits under Medicare Part B, or are within the guaranteed issue period, your rate will not be affected by your weight, height, smoking status, claims experience, receipt of health care or medical condition.

Nine-digit Social Security number*	**Michigan driver's license or Michigan ID number***
___ ___ ___ – ___ ___ – ___ ___ ___ ___	

Please refer to your red, white and blue Medicare Health Insurance card to complete this section.

Please fill in these blanks so they match the information on your Medicare card.

MEDICARE **HEALTH INSURANCE**

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

_____

MEDICARE CLAIM NUMBER

_____–_____–_____–____

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL (PART A)	_____–_____–_____
MEDICAL (PART B)	_____–_____–_____

Continue to next page

Step 2: Information about you, *continued*

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 Medigap policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medigap plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS. Please mark the Yes or No boxes below with an X. To the best of your knowledge:

Did you turn age 65 and/or enroll in Medicare Part B in the last 6 months? If so, what is the effective date? _____	☐ **Yes** ☐ **No**
Are you currently covered by Medicaid (State assistance)? *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 so, will Medicaid pay your premiums for this Medigap policy?	☐ **Yes** ☐ **No**
Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ **Yes** ☐ **No**
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. **Start date** ____/____/_____ **End date** ____/____/_____	
If you're still covered under the Medicare plan, do you intend to replace your current coverage with this new Medigap policy?	☐ **Yes** ☐ **No**
Was this your first time in this type of Medicare plan?	☐ **Yes** ☐ **No**
Did you cancel a Medigap policy to enroll in this Medicare Advantage plan?	☐ **Yes** ☐ **No**

If you had coverage under a Medicare Advantage policy and it is no longer in force, please check one of the following reasons:

- ☐ CMS terminated the certification of the organization or plan.
- ☐ The Medicare Advantage Organization stopped offering Medicare Advantage plans.
- ☐ The Medicare Advantage Organization stopped offering coverage in the area in which you live.
- ☐ You moved out of the geographic service area of your Medicare Advantage plan.
- ☐ Voluntarily disenrollment because plan violated a material provision of the policy or insurer materially misrepresented the policy's provisions in marketing the policy to individuals.
- ☐ You disenrolled from a Medigap policy to join a Medicare Advantage plan for the first time, have been in the Medicare Advantage plan less than a year and you want to switch back to Original Medicare.
- ☐ You joined a Programs of All-inclusive Care for the Elderly (PACE) plan when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decided you want to switch to Original Medicare
- ☐ You dropped a Medigap policy to join a Medicare Advantage plan for the first time; you have been in the plan less than a year and you want to switch back.
- ☐ Other: _____

Did you enroll in Medicare Advantage when you became eligible for Medicare Part A and Part B, but voluntarily disenrolled from the plan within 12 months of the effective date of enrollment?	☐ **Yes** ☐ **No**

IMPORTANT: If you are currently enrolled in a Medicare Advantage plan and wish to enroll in Medigap, you **must** separately disenroll in writing from Medicare Advantage. Submission of this application does not automatically disenroll you from your current Medicare Advantage insurance carrier. Call your Medicare Advantage customer service department for information on how to disenroll from that plan and prevent duplication of coverage and/or a lapse in coverage. Medicare Advantage plans only allow disenrollment at certain times of the year.

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Do you have, or did you have, another Medigap policy in force? ☐ Yes ☐ No

If so, with what company and what plan? _____

_____

What are your dates of coverage under that policy?

Start date ____/____/_____ **End date** ____/____/_____

If your Medigap policy is no longer in force, indicate the reason:

- ☐ Involuntary disenrollment because insolvency of insurer or bankruptcy of organization offering the coverage
- ☐ Voluntary disenrollment because plan violated a material provision of the policy or insurer materially misrepresented the policy's provisions in marketing the policy to individuals
- ☐ Employer group/union paid after Original Medicare, and that plan is ending.
- ☐ Other_____

If so, do you intend to replace your current Medigap policy with the MyBlue Medigap policy? ☐ Yes ☐ No

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 so, with what company? _____

Type of policy _____

Policy number _____

What are your dates of coverage under that policy?

Start date ____/____/_____ **End date** ____/____/_____

If the plan is no longer in force, what is the reason your coverage ended?

- ☐ Involuntary disenrollment because the group plan sponsor stopped offering coverage
- ☐ Voluntary disenrollment

If available, please include proof of prior coverage termination with this application. If you're applying online, please mail proof of prior coverage termination along with a copy of your MyBlue Medigap online enrollment confirmation to Mail Code C411, Blue Care Network of Michigan, P.O. Box 5043, Southfield, MI 48086-5043.

Conditions of coverage

- I am applying for MyBlue Medigap coverage. I certify that I am enrolled in both Part A and Part B of Medicare.
- The product for which you are applying for is a medically underwritten product offered by Blue Care Network. You must provide evidence of good health in order to be eligible for this health plan. If you have received treatment for certain medical conditions within the last five years, including taking prescription drugs, you may not be eligible for this product.
- I authorize Blue Care Network of Michigan (BCN) to obtain from providers of service and hospitals the medical records relating to me necessary to the administration of my contract with BCN.
- I assign BCN my entire right of recovery of the cost of hospital and medical services paid for by BCN against any person or organization as a result of accident or disease, including injuries or disease claimed under worker compensation laws or acts whether by redemption award, voluntary payment or otherwise.
- I understand that the benefits I will be eligible for are described in the MyBlue Medigap certificate and that the BCN marketing materials are only a summary.
- I certify that the above information is true, correct and complete to the best of my knowledge and belief. I understand the information will be used in reviewing my application and administering coverage and my failure to provide complete and accurate answers or my submission of false or misleading information may result in denial of claims, cancellation or rescission of the policy.
- I certify that I am a permanent resident of Michigan and have a valid Michigan driver's license or Michigan ID card, and reside at least six months of each year at my permanent residence in Michigan.

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Step 3: Please read and sign

- You do not need more than one Medigap policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid and may not need a Medigap policy.
- Health conditions which you may presently have (pre-existing 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.
- Your insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medigap 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 Medigap 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 Medigap 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.
- I understand that providing fraudulent information about my permanent residence, date of birth, height, weight, health status and tobacco use may result in cancellation of my policy, restitution and possible legal action against me by BCN for fraud.
- If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded.
- Acceptance of non-guaranteed issue enrollees will be subject to medical underwriting.
- Counseling services may be available in your state to provide advice concerning your purchase of Medigap insurance and concerning Medicaid. A copy of the *Guide to Health Insurance for People with Medicare* is available on the Medicare website at **www.medicare.gov/publications/pubs/pdf/02110.pdf**.
- Depending on information received, an individual may not meet the eligibility requirements for MyBlue Medigap membership.

The following questions *must* be completed by enrollees.

If you are not applying within the guaranteed issue period, please answer the following questions and submit them with your application. Your application will not be processed until we receive your answers.

1.	Have you had a complete physical within the past two years? If yes, what was the date of the exam? _____ Physician's name: _____ Address: _____ Phone number: _____	☐ Yes ☐ No
2.	Has a physician advised or recommended that you have treatment, medical tests, surgery or therapy for any condition in the next 12 months?	☐ Yes ☐ No
	Have the recommended services been obtained?	☐ Yes ☐ No

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3.	Are you currently disabled, hospitalized, or confined to a facility such as a skilled nursing facility?	☐ Yes ☐ No
4.	Have you been hospitalized or confined to a nursing facility in the past five years?	☐ Yes ☐ No
5.	Have you had an organ transplant or been advised by a physician to have an organ transplant (includes heart, liver, kidney, pancreas, lung, or bone marrow)?	☐ Yes ☐ No
6.	Have you been diagnosed or treated (including taking medication) for the following condition(s) in the past five years?	
	• Emphysema, chronic obstructive pulmonary disease (COPD), chronic pulmonary disorders (includes bronchitis) or tuberculosis?	☐ Yes ☐ No
	• Parkinson's disease, systemic lupus, myasthenia gravis, multiple or lateral sclerosis (including amyotrophic lateral sclerosis)?	☐ Yes ☐ No
	• Alzheimer's disease, senile dementia, or other cognitive disorder?	☐ Yes ☐ No
	• Acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or any autoimmune disease?	☐ Yes ☐ No
	• Diabetes Type I or Type II	☐ Yes ☐ No
	• Have you had any amputations?	☐ Yes ☐ No
	• Do you have a history of cancer?	☐ Yes ☐ No
	• Cirrhosis of the liver, or hepatitis?	☐ Yes ☐ No
	• Chronic kidney disease or any kidney disorder including end stage renal disease (ESRD) or dialysis? Any history of kidney stones?	☐ Yes ☐ No
	• Hemophilia or other clotting disorders?	☐ Yes ☐ No
	• Heart attack, angina pectoris, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure (CHF) or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	☐ Yes ☐ No
	• Degenerative bone disease, rheumatoid arthritis, or have you been advised to have a joint replacement?	☐ Yes ☐ No

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Include any additional information below for 'yes' answers on questions 1 through 6. Use additional sheets if needed.			
Question number	**Dates of care**	**Information regarding question or condition**	**Physician's name and phone #**

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7. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If yes, please list the medication and requested information on the following table (use additional sheets if needed).	☐ **Yes** ☐ **No**

MEDICATION NAME (from your pharmacy or over-the-counter label)	
Date originally prescribed	
Prescribing physician	
Frequency and dosage	
Diagnostic condition	
MEDICATION NAME (from your pharmacy or over-the-counter label)	
Date originally prescribed	
Prescribing physician	
Frequency and dosage	
Diagnostic condition	
MEDICATION NAME (from your pharmacy or over-the-counter label)	
Date originally prescribed	
Prescribing physician	
Frequency and dosage	
Diagnostic condition	
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Date originally prescribed	
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Diagnostic condition	
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Date originally prescribed	
Prescribing physician	
Frequency and dosage	
Diagnostic condition	

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Authorization for use and disclosure of protected health information (PHI)

I understand that Blue Care Network (BCN) may collect personal and protected health information (PHI) about me in order to complete my application for coverage. BCN will use and disclose this information only in accordance with their Notice of Privacy Practices which is available on www.**bcbsm.com** or by calling 313-225-9000.

I authorize:

- Use and disclosure of my PHI, including membership, eligibility and claims data stored on Blue Cross Blue Shield of Michigan and its subsidiaries' computer systems.
- Physicians, health care professionals, hospitals, clinics, laboratories, pharmacies or pharmacy benefit managers, or other health care providers that have provided treatment or services to me or any of my dependents who are also applying for coverage to disclose medical records, prescription history, medications prescribed and other PHI as requested to BCN.
- Health plans, governmental agencies or prescription drug profiling companies that have a previous relationship with me or who have knowledge of my medical information or the medical information of any of my dependents who are also applying for coverage to disclose medical records information, prescription history, medications prescribed and other PHI as requested to BCN.

My authorization includes disclosure of information on the diagnosis and treatment of Human Immunodeficiency Virus (HIV) infection and treatment of mental illness and the use of alcohol, drugs and tobacco, but excludes disclosure of psychotherapy notes.

This authorization includes and applies to any and all protected health information related to treatments or services where I have requested a restriction and/or for any health care item or service for which the health care provider has been paid out of pocket in full.

This PHI is to be disclosed so that BCN may: (1) perform case, care and disease management, (2) administer claims and determine or fulfill responsibility for coverage and provision of benefits, and (3) for other legally permissible purposes, including but not limited to, health care operations. If BCN discloses this information, the recipient must obtain an additional authorization from me before it may re-disclose the information and if I provide this authorization information may be re-disclosed by the recipient and is no longer protected.

I understand that my enrollment with BCN is conditioned upon my authorization to release PHI for the purposes stated above and that if I do not provide authorization, I may not be eligible for enrollment. My signature on this form indicates my approval for the release of PHI from BCBSM and its subsidiaries and from any of the parties listed above to BCN. A photographic copy of this authorization shall be valid as the original.

This authorization will expire after 30 months or upon rejection of coverage. I understand that I am entitled to receive a copy of this authorization upon request. I may revoke this authorization at any time by sending a written request on a standard form available online at www.**bcbsm.com** or by contacting my agent. I understand that revocation will not affect actions taken before BCN or any of the parties identified above receive my request.

I have read and authorize MyBlue Medigap to use my medical and drug information.

Your signature	**Date**

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I have read and agreed to the terms on this form. I understand that approval of this application and coverage effective date will be determined by Blue Care Network of Michigan. If I cancel within the first 30 days of the effective date of this coverage, I will be entitled to a refund of my previous premium payment. *Please note: The reasonable costs for any health services paid by BCN during that time period will be deducted from the refund and I will be responsible for payment of reasonable fees for any health care services I received.* If I choose to cancel my coverage after the first 30 days, I understand there is a 30-day advance notice required by BCN.

I have received and read (1) this brochure outlining MyBlue Medigap coverage, and (2) the information above concerning replacement of existing health coverage with the MyBlue Medigap policy.

Your signature	**Date**

Be sure that you have completed all portions of this application, then mail completed form to:

Mail Code C411
Blue Care Network of Michigan
P.O. Box 5043
Southfield, MI 48086-5043.

Use one application for each person. For faster processing, you may use the online enrollment application at **www.bcbsm.com.** instead of submitting a paper application. If you have questions, or if you would like to enroll by phone, please call 888-563-3307 or contact your Blue Cross Blue Shield of Michigan insurance agent. TTY users should call 711.

Note to applicant: *If you are replacing a Medigap or Medicare Advantage policy with this MyBlue Medigap policy, you must also complete the following page. If you're purchasing this policy through an insurance agent or broker authorized to sell Blue Care Network policies, your agent or broker must also sign this form. If you're completing this application on your own, please skip the section on the next page, "Statement to applicant by insurer, agent or other representative," and the entire page titled "For Agent Use."*

If you wish to enroll in the Automatic Payment program, you must complete the Authorization Agreement for Automatic Payments form on the last page of this booklet.

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