Blue Cross® Medicare Supplement
Plans A, C, D, F, High-Deductible F, G, High-Deductible G and N Application
2020 Medicare supplement application

Applicant information

Please print in black or blue ink. All sections must be completed unless otherwise indicated. All information provided will be used and disclosed only as permitted by our Notice of Privacy Practices which can be found at www.bcbsm.com. We only use your information for understanding and processing your application. All information you provide is confidential.

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<th>First name</th>
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<th>Last name</th>
<th>Social Security number</th>
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<tbody>
<tr>
<td>Primary street address (cannot be a P.O. Box)</td>
<td>City</td>
<td>State</td>
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<td>Mailing street address (if different from above)</td>
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Number of months you reside in MI each year
You don’t have to answer this question if you’re in your open enrollment or guaranteed issue period.
Have you used tobacco in any form in the past year? ☐ Yes ☐ No

Did you have a Blue Cross Medicare Supplement or Legacy Medigap plan that terminated in the past six months? ☐ Yes ☐ No

If yes, enrollee ID number:

Household discount eligibility
You may be eligible for a lower premium if another person in your household currently has a Blue Cross Medicare Supplement or Legacy Medigap plan. Household is defined as a single-family home, a condominium unit or an apartment unit within an apartment complex.

Please check the box below that applies to you:

☐ I live with a person who’s currently covered under a Blue Cross Medicare Supplement plan or Legacy Medigap plan.
Name of that person ___________________________ Enrollee ID number* of that person ___________________________

☐ I live with a person who is in the process of applying for a Blue Cross Medicare Supplement plan.
Name of that person ___________________________ Social Security number of that person ___________________________

☐ I don’t currently live with another person who has a Blue Cross Medicare Supplement plan or Legacy Medigap plan, and I’m not eligible for the household discount.

*Enrollee ID number is found on the Blue Cross member ID card.
Please refer to your red, white and blue Medicare health insurance card to complete this section.

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

2 Plan selection

Please check the appropriate box for the plan you want:

- [ ] Plan A
- [ ] Plan C
- [ ] Plan D
- [ ] Plan F
- [ ] Plan HD-F
- [ ] Plan G
- [ ] Plan HD-G
- [ ] Plan N

Please note that HD means high-deductible plan.

If any of the below information applies to you, we consider you eligible as a conversion member. This means that if you apply for one of these Medicare supplement plans for which you are eligible within 180 days after you lost coverage under a group policy, you are entitled to the plan without restriction.

- If you turned 65 years old, or became Medicare eligible on or after January 1, 2020, you can’t enroll in a plan that covers the Part B deductible (Plans C, F and High-Deductible F).

- You are eligible for **Plan C** if you turned 65 or became eligible for Medicare prior to January 1, 2020. You can enroll in Plan C if you’ve lost coverage under a group policy after becoming eligible for Medicare. You’re also eligible if you had Plan C, then enrolled in a Medicare Advantage plan, and now would like to return to Plan C. You can do this as long as it’s within the first 12 months of your Medicare Advantage plan.

- You are eligible for **Plan D** if you turned 65 or became eligible for Medicare due to disability or end stage renal disease, on or after January 1, 2020. You can enroll in Plan D if you’ve lost coverage under a group policy after becoming eligible for Medicare.

- You’re automatically eligible for **Plan A** or **Plan D**. If you’re younger than 65, you’re eligible only for Plan A or Plan D if you’ve lost coverage under a group policy after becoming eligible for Medicare. You’re also eligible if you had Plan A, then enrolled in a Medicare Advantage plan, and now would like to return to Plan A. You can do this as long as it’s within the first 12 months of your Medicare Advantage plan.

**Requested future start date:** ____ / 01 / _____

When choosing a plan, it’s important to know the following:

- You must be enrolled in Medicare Parts A and B.
- You can’t have more than one Medicare supplement plan.
- You can’t be enrolled in a Medicare Supplement plan and a Medicare Advantage plan at the same time.
- You must be a permanent resident of Michigan and physically live in Michigan for at least six months of every year to be eligible for coverage.
- Once enrolled, if you permanently move outside of Michigan or live in Michigan for fewer than six months of every year, your premium may change.
- Coverage will only continue if all other eligibility requirements continue to be satisfied. Refer to the Outline of Coverage at [www.bcbsm.com/medicare-supplement](http://www.bcbsm.com/medicare-supplement) for the monthly cost and description of the plan.
- If you are younger than 65, you are eligible to enroll in Plans A and D only.
Medicaid information

If you are 65 or older, you may be eligible for benefits under Medicaid, and may not need a Medicare Supplement plan.

Are you covered for medical assistance through the state Medicaid program? □ Yes □ No

(Note: If you’re participating in a spend-down program and haven’t met your out-of-pocket cost maximum, please answer “No” to this question.)

If yes: Will Medicaid pay your premiums for this Medicare Supplement plan? □ Yes □ No

Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium? □ Yes □ No

If, after purchasing a Medicare Supplement plan, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement plan may 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’re no longer entitled to Medicaid, your suspended Medicare Supplement plan may be available. If it’s no longer available, a substantially equivalent plan will be reinstated 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 re-instituted policy won’t have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

Open enrollment period

A. Will you be 65 or older by (or on) the first day of the month following your effective month?
   □ Yes □ No, I am under 65 and eligible for Medicare due to disability or ESRD, end stage renal disease.

   If you answered no and are under the age of 65, please note that you are only eligible for Plans A & D.

B. Are you turning 65 the same month or no more than six months prior to the first day of your requested effective month?
   □ Yes □ No, I turned 65 more than six months ago.

C. Is your Medicare Part B effective date the same month or no more than six months prior to the first day of your requested effective month?
   □ Yes □ No, I enrolled in Part B more than six months ago.
Guaranteed issue rights

Guaranteed issue, or GI, rights mean you can’t be turned down for Medicare Supplement coverage or be charged extra for pre-existing health conditions when you enroll within the special enrollment period.

You may pay a higher premium or be denied for certain predetermined health conditions if you enroll outside of the special enrollment period.

A. Do you have another active Medicare Supplement policy? □ Yes □ No

If so, name the company and the plan.

If so, do you intend to replace your current Medicare Supplement policy with this policy?
□ Yes □ No (If no, you aren’t eligible for this Medicare Supplement plan.)

If the Medicare Supplement plan has ended, why did it end?
□ Through no fault of my own
□ Company misled me or failed to follow the rules
□ Other

B. Have you lost or are you losing other health coverage, received a notice from your previous health plan saying you’re eligible for guaranteed issue of a Medicare Supplement plan, or that you had certain rights to buy a guaranteed issue plan?
□ Yes Start date ____________

End date (If you’re still covered under this plan, leave the end date blank): ____________

Reason for disenrollment: ________________________________________________________________

□ No

C. Are you enrolled, or were you previously enrolled, in a Medicare Advantage plan?
□ Yes Start date: ____________ □ No

End date (If you’re still covered under this plan, leave the end date blank): ____________

If “Yes,” name the carrier you were enrolled with: __________________________________________

If “Yes,” select the reason you disenrolled.
□ Plan is leaving Medicare.
□ Plan is no longer offered in my area.
□ I’m moving out of the plan’s service area.
□ I replaced a Medicare Supplement policy (or switched to a Medicare SELECT policy) for the first time, have been in the plan less than a year and now wish to return to my previous Medicare supplement policy. This is considered a “trial right.”
□ Voluntary disenrollment.
□ I joined a Medicare Advantage plan (or PACE) when I was first eligible for Medicare Part A at 65, and within the first year of joining I decided to switch to Original Medicare and join a Medicare Supplement plan. This is also considered a “trial right.”
□ Company misled me or failed to follow the rules.
□ Other __________________________________________

D. Do you have Original Medicare and a Medicare SELECT policy, and have moved out of the Medicare SELECT policy service area?
□ Yes □ No
E. Did you have 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)?

☐ Yes  ☐ No

If yes, indicate your start and end dates below. If you’re still covered under this plan, leave the end date blank.  **Start date ____________ End date ____________**

Was this your first time in this type of Medicare plan?

☐ Yes  ☐ No

Did you cancel a Medicare Supplement policy to enroll in the Medicare plan?

☐ Yes  ☐ No

F. 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 and what kind of policy?

_________________________________________________________

What are your dates of coverage under the other policy? (If you’re still covered under the other policy, leave end date blank.)  **Start date ____________ End date ____________**

If the plan has ended, why did it end?

☐ My coverage ended due to the death of or divorce from my spouse, I became eligible for Medicare and my coverage is no longer available or my employer no longer offers group coverage.

☐ I voluntarily canceled my coverage due to cost, benefits or another reason.

**Important note:** If you’re currently enrolled in a Medicare Advantage plan and want to enroll in Medicare Supplement, you must separately disenroll in writing from Medicare Advantage. Submission of this application doesn’t 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 or a lapse in coverage. Medicare Advantage plans only allow disenrollment certain times of the year.

If you indicated your employer or group health plan is ending your coverage (through no action of your own), or that you received a notice from a prior health plan that you have a right to buy a GI plan, scan and email a copy of the termination or GI notice to MedSuppUnderwriting@bcbsm.com or fax it to 1-877-205-6651. Be sure your first and last name are clearly legible on the email or fax.

6  Conversion rights (for Plans A, C and D)

Have you lost, or will you lose, coverage under a group policy after becoming eligible for Medicare?

☐ Yes  ☐ No

If yes, what is the date you lost, or will lose, coverage? ______________

Note: You aren’t eligible to enroll in Plan C if you became 65 or qualified for Medicare due to age, disability or end stage renal disease on or after January 1, 2020.

If you’re applying for Plans A, C, or D, you must submit proof that you’ve lost coverage under a group policy after becoming eligible for Medicare.
Health information for nonguaranteed issue

Complete this section if you aren’t applying during your open enrollment or guaranteed issue period.
The information you provide is confidential and will be used and disclosed only as permitted by our Notice of Privacy Practices, which can be viewed online at www.bcbsm.com.

Height: __________ ft. __________ in.  Weight: __________ lbs.

A. Do any of these apply to you? Please check all that apply.

☐ AIDS or HIV+  ☐ Amyotrophic lateral sclerosis (ALS)  ☐ Cardiomyopathy  ☐ Cerebral palsy  ☐ Currently receiving dialysis  ☐ Cystic or pulmonary fibrosis  ☐ End stage renal disease (ESRD)  ☐ Gaucher’s or Pompe disease  ☐ Growth hormone deficiency  ☐ Hemophilia  ☐ Hepatitis C  ☐ Hospital inpatient within past 90 days

☐ Huntington’s disease  ☐ Kidney disease that may require dialysis  ☐ Leukemia, lymphoma, malignant melanoma  ☐ Muscular dystrophy  ☐ Organ or bone marrow transplant  ☐ Paraplegia, quadriplegia or hemiplegia  ☐ Pulmonary arterial hypertension  ☐ Spinocerebellar disease  ☐ Stroke  ☐ Other metabolic disorders  ☐ Other neurodegenerative disorders  ☐ None of these apply

B. Within the past two years, has a medical professional discussed any of the following treatment options that haven’t yet been addressed? Please check all that apply.

☐ Hospital admittance as an inpatient  ☐ Organ transplant  ☐ Back or spine surgery  ☐ Joint replacement

☐ Surgery, radiation or chemotherapy for cancer  ☐ Heart surgery  ☐ Vascular surgery  ☐ None of these apply

C. Have you been diagnosed or treated (including taking medication) for any of the following conditions in the past five years? Please check all that apply.

Heart or vascular conditions

☐ Angina or heart attack  ☐ Atrial fibrillation or flutter  ☐ Coronary or carotid artery disease  ☐ Congestive heart failure

Lung or respiratory conditions

☐ COPD or emphysema

Cancers or tumors

☐ Cancer (other than skin cancer)

Nervous system conditions

☐ Alzheimer’s disease or dementia  ☐ Multiple sclerosis  ☐ Parkinson’s disease

Diabetes

☐ With any of the following complications: circulatory problems, kidney problems or eye problems

Kidney conditions

☐ Chronic kidney disease

Liver conditions

☐ Cirrhosis

Immune system conditions

☐ Crohn’s disease or ulcerative colitis  ☐ Lupus  ☐ Rheumatoid arthritis  ☐ Other immune deficiency

Psychological conditions

☐ Bipolar or schizophrenia  ☐ Major depression

☐ None of the conditions in question C apply
D. Do you have any of the following chronic health conditions? Please check all that apply.

- Anxiety or mild depression
- Arthritis (hip or knee)
- Asthma
- Diabetes (with no complications)
- Enlarged prostate (BPH)
- Fibromyalgia
- GERD or acid reflux
- Glaucoma or macular degeneration
- High blood pressure
- High cholesterol
- Hypothyroidism or hyperthyroidism
- Migraines
- Myasthenia gravis
- Osteoporosis
- Psoriasis
- None of these apply

Have you had any drugs administered in the doctor’s office or hospital in the last 12 months?  □ Yes  □ No

List names of drugs:


List prescriptions you’ve taken in the last 12 months (If more room is needed, please list on a separate page and attach to your application):
Authorization for protected health information use and disclosure (required if applying outside your open enrollment or guaranteed issue period)

I understand that the following parties may need to collect information on me in regard to the proposed coverage: Blue Cross Blue Shield of Michigan and its reinsurers, any insurance support organization, any consumer reporting agency, and all persons authorized to represent these organizations for this purpose.

Any and all individually identifiable health information, including but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results may be disclosed to or by Blue Cross Blue Shield of Michigan.

Those parties who may need to collect information may disclose information to the following: Other insurers to whom I’ve applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearinghouses; or persons who perform business, professional or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 30 months after the date signed.

I understand I can revoke this authorization any time by giving written notice on a standard form available online at www.bcbsm.com, or by contacting my agent. I also understand that my revocation won’t affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but if I don’t, I may not be eligible for enrollment. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

Applicant printed name

Applicant signature | Date
Additional information
You don’t need more than one Medicare Supplement plan.

- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

- If you’re eligible for, and have enrolled in, a Medicare Supplement plan because of a 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’re 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 reinstated 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 reinstated policy won’t have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

- Your coverage will automatically be renewed each year as long as you pay your premiums.

To terminate your Blue Cross Medicare Supplement plan, please notify
Blue Cross Blue Shield of Michigan in writing or call Customer Service at 1-888-216-4858 from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users, call 711.

Counseling services may be available in your state to provide advice about your purchase of Medicare Supplement insurance and Medicaid.
Confirm and sign

Please read, sign and date where indicated.

My signature indicates that I’ve read and understand the contents of this application. I declare that the answers on this application are complete and true to the best of my knowledge and belief, and are the basis for issuing coverage. I understand that the application and amendments become a part of the contract and that if the answers are incomplete, incorrect or untrue, Blue Cross Blue Shield of Michigan may have the right to rescind my Blue Cross Medicare Supplement coverage or adjust my premium. I understand that I may not be eligible for all offered plans, and confirm that I haven’t applied for any plan for which I’m not eligible.

If I cancel within the first 30 days of the effective date of this coverage, I’ll be entitled to a refund of my previous premium payment. Please note that the reasonable costs for any health services paid by Blue Cross 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 I must write or call Blue Cross’ Customer Service department.

Any person who knowingly, and with intent to defraud any health plan company or other person, files an application 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 act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand the coverage under the plan I’m applying for won’t take effect until issued by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan requires proper handling of personal health information for its members. Details of Blue Cross Blue Shield of Michigan confidentiality policies and procedures are available at www.bcbsm.com.

☐ Yes  ☐ No  I have received a copy of Blue Cross’ Medicare Supplement plan Outline of Coverage.

☐ Yes  ☐ No  I have received a copy of Choosing a Medigap Policy.

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<th>Applicant’s signature</th>
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You will receive an ID card and a Certificate of Coverage with a letter confirming your effective date and premium.

If you’re the authorized personal representative, or have an authorized representative currently on file with Blue Cross, you must provide the following information:

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<th>Phone</th>
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Applications can be submitted in the following ways:

Online:  [www.bcbsm.com/medicare-supplement](http://www.bcbsm.com/medicare-supplement)
Fax:  1-866-392-7528
Mail:  Blue Cross Blue Shield of Michigan
        P.O. Box 44407
        Detroit, MI 48244-0407

Agents must submit applications online at [www.bcbsm.com/agents](http://www.bcbsm.com/agents).

10 Agent use

Enrolling an individual in a Medicare Supplement plan requires that you provide the following information.

1. Have you sold any other health plan policies to this individual that are still in force?
   - [ ] Yes  Policy descriptions (name of policy, policy number, start date):

   ____

   - [ ] No

2. Have you sold any health plan policies to this individual in the last five years that aren’t still in force?
   - [ ] Yes  Policy descriptions (name of policy, policy number, start and end dates):

   ____

   - [ ] No

3. Did you ask the applicant all the questions in this application and record the answers as given to you?
   - [ ] Yes
   - [ ] No

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<th>MA/GA 2-digit code</th>
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<td>Email address</td>
<td>Primary phone</td>
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<td>Fax</td>
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<tr>
<td>Agent’s first and last name</td>
<td>Agent 5-digit code</td>
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<td>Date agent accepted application</td>
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<tr>
<td>Name of person who entered application online</td>
<td>Blue Cross badge ID</td>
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<td>Blue Cross source code</td>
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Applications must be submitted online at [www.bcbsm.com/agents](http://www.bcbsm.com/agents), or submitted to the managing agent or general agent within 24 hours of accepting the applicant’s paper application.
Notice to applicant about replacement of Medicare Supplement coverage

Save this notice. It may be important to you in the future.

According to your application or the information you furnished, you intend to drop or otherwise terminate existing Medicare Supplement coverage or a Medicare Advantage plan and replace it with a new certificate to be issued by Blue Cross Blue Shield of Michigan. Your new certificate provides 30 days within which you may decide, without cost, whether you want to keep the certificate.

You should review this new coverage carefully, comparing it with all disability and other health coverage you now have. You should terminate your present coverage only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

Statement to applicant by Blue Cross’ Medicare Supplement agent, broker or other representative:

I’ve reviewed your current medical or health coverage as disclosed to me. The replacement of coverage involved in this transaction doesn’t 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, to the best of my knowledge. The replacement plan is being purchased for the following reason (check one):

- Additional benefits
- No change in benefits, but lower premiums
- Fewer benefits and lower premiums
- Current plan has outpatient prescription drug coverage and I’m enrolling in Part D
- Disenrollment from a Medicare Advantage plan
  Reason for disenrollment _____________________________
- Other (please specify) _____________________________
- Didn’t replace existing Medicare supplement coverage

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 refund your premium as though your policy or certificate had never been in force. Before you sign your completed application, review it carefully to be certain that all information has been properly recorded.

Don’t cancel your present policy until you’ve received your new certificate and are sure you want to keep it.
The *Notice to Applicant* was delivered to me by my agent on (date): _____________.

I delivered the *Notice to Applicant* on (date): _____________.

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<th>Signature of agent, broker or other representative (signature not required for direct response sales)</th>
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<td>Printed name of agent</td>
<td>Agent number</td>
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<td>Agent's street address</td>
<td>City</td>
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Policy, certificate or contract number being replaced
Notes
Notes