



## APPLICATION COMPLETION INSTRUCTIONS

1. Applicant must be age 65 or older and a Nebraska resident at time of enrollment.
2. If you need more space for any answers, you can use a separate piece of paper.

### FOR YOUR INFORMATION

- a. You do not need more than one Medicare supplement policy.
- b. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- c. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- d. 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 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- e. 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 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 will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- f. 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).
- g. If you are enrolled under a Medicare Advantage plan, you are not eligible for a Medicare Supplement policy in addition to that plan.

### THIS IS NOT A CONTRACT

Blue Cross and Blue Shield of Nebraska reserves the right to accept or decline this application in whole or in part except when application is made during the initial six month open enrollment period beginning with the first month in which you are first enrolled under Medicare Part B and you are 65 years of age or older. No right is created by this application including any advance premium payment and the application shall not be considered accepted unless the contract is actually issued to you.

Once you have received your contract you have 30 days to return it to Blue Cross and Blue Shield of Nebraska and any premium you have paid will be refunded.

Should you discontinue Medicare Part B Medical Insurance Benefits, it shall be your responsibility to notify Blue Cross and Blue Shield of Nebraska of the change.

**THIS APPLICATION IS SUBJECT TO THE APPROVAL OF BLUE CROSS AND BLUE SHIELD OF NEBRASKA.**

**A. IDENTIFYING INFORMATION**

1a. Social Security Number		1b. Name (Last, First, M.I., Title)		
1c. Address (Street, P.O. Box, City, State, Zip+4 Code, County)				E-mail Address
1d. MEDICARE INFORMATION: (Located on your Red, White, and Blue Medicare Card)				
Medicare Claim Number		Hospital Insurance Effective Date		Medical Insurance Effective Date
1e. Do you now have or have you formerly had Blue Cross and Blue Shield coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give Identification Number (located on your Blue Cross and Blue Shield Card) and Plan's City and State:				
1f. Date of Birth (Mo., Day, Year)	1g. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	1h. Group Number	1i. Telephone Number (     )	Most convenient time <input type="checkbox"/> Day <input type="checkbox"/> Evening

**B. PLAN ELECTION - ENROLL ME FOR:**

**BlueSenior Classic:**  Plan G     Plan F     Plan C     Plan B     Plan A

Please check applicable box below.

- I have not smoked or used tobacco products during the past 12 months.
  - I have smoked or used tobacco products during the past 12 months.
- (Smoking and/or use of tobacco products means any use of cigarettes, pipes, cigars, or any other tobacco products regardless of the number of times or frequency of use.)

**C. PAYMENT INSTRUCTIONS**

Quarterly (If quarterly selected, attach check for the initial premium payment.)

Monthly Bank Debit (If Bank Debit, complete payment authorization section below and **attach a voided check.**)

I authorize Blue Cross and Blue Shield of Nebraska to initiate debit entries (charges) to my account indicated below, and the Financial Institution named below to charge the said account. This authority is to remain in full force and effect until the Financial Institution has received written notification from me of its termination in such time as to afford the Financial Institution a reasonable opportunity to act on it. The initial authorization is for \$\_\_\_\_\_ to be charged to my account on or after the 20th day of each month. Such amount may be changed from time to time by Blue Cross and Blue Shield of Nebraska giving me written notice before changing said account. I understand that premiums will continue to be withdrawn unless or until Blue Cross and Blue Shield of Nebraska receives a written request to terminate coverage or a stop payment is made. Termination will take effect the last day of the month after receipt of the request for termination.

Depository Institution Name: \_\_\_\_\_

City, State and Zip: \_\_\_\_\_

Account Number: \_\_\_\_\_  Checking  Savings

**D. TO THE BEST OF YOUR KNOWLEDGE:**

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. Please mark Yes or No below with an "X".**

To the best of your knowledge:

1. (a) Did you turn age 65 in the last 6 months? Yes\_\_\_ No\_\_\_
- (b) Did you enroll in Medicare Part B in the last 6 months? Yes\_\_\_ No\_\_\_
- (c) If yes, what is the effective date? \_\_\_\_\_
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\_\_\_

**D. CONTINUED:**

- 3. (a) 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 below. If you are still covered under this plan, leave "End" blank. **Start** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**End** \_\_\_\_ / \_\_\_\_ / \_\_\_\_
- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this Medicare supplement policy? Yes\_\_\_ No\_\_\_
- (c) Was this your first time in this type of Medicare 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? Yes\_\_\_ No\_\_\_
- (b) If so, with what company, and what plan do you have? \_\_\_\_\_
- (c) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes\_\_\_ No\_\_\_
- 5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes\_\_\_ No\_\_\_
- (a) If so, with what company and what kind of policy? \_\_\_\_\_
- (b) What are your dates of coverage under the other policy? **Start** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**End** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ (If you are still covered under the other policy, leave "End" blank.)

**E. STATEMENT OF HEALTH**

(Not applicable if you qualify for open enrollment under federal and state guidelines.)

**Height** \_\_\_\_\_ feet \_\_\_\_\_ inches **Weight** \_\_\_\_\_ pounds

Past History (Answer each question "Yes" or "No." For conditions answered "Yes," give details below). Yes No

- 1. Do you live in a nursing home or require home health care services? .....
- 2. Have you ever had skin cancer? If "Yes," describe type: Basal cell \_\_\_\_ Squamous cell \_\_\_\_  
Other \_\_\_\_\_ .....
- 3. Have you ever had cancer in any form? .....
- 4. Have you ever had a heart attack? .....
- 5. Have you ever had a stroke? .....
- 6. Have you ever had chest pain, heart disease or heart surgery? .....
- 7. Do you have diabetes? .....
- 8. Do you regularly take prescription drugs? .....
- 9. Do you receive dialysis treatment? .....

Show full details for "Yes" answers to any part of Section E. (List Prescription Drugs and reason for taking if question E8 answered yes).

Question Number	Dates:		Describe Rx, Treatment or Operation
	From	To	

**F. EMPLOYER GROUP INFORMATION: (Complete this section if transferring from an employer sponsored plan)**

Name of Insurance Carrier: \_\_\_\_\_

Name of Employer \_\_\_\_\_ Group Number: \_\_\_\_\_

Reason for leaving other coverage:  Retirement  Voluntary transfer  Other: \_\_\_\_\_

\_\_\_\_\_ Date coverage ends (M,D,Y): \_\_\_\_\_

If you are a current Blue Cross and Blue Shield member, check here if you desire guaranteed coverage under Plan B.

I understand I may apply for Plan C, Plan F or Plan G with medical underwriting. If I do not pass medical underwriting, I will continue on Plan B.

Employer is terminating all Medicare Supplement benefits.

Date group coverage ends (M,D,Y): \_\_\_\_\_

**G. STATEMENTS BY APPLICANT:**

I acknowledge receipt of the following documents at the time I completed this application:

- Outline of Coverage
- Pamphlet "Guide to Health Insurance for People with Medicare"

Coverage will be effective the first of the month following approval. If you wish to request an earlier effective date, you may do so here: \_\_\_\_\_ If an effective date is requested and approved, I understand I cannot request a change of that date, and that premiums are owed from that date forward.

If my application was taken by a depositor bank agent, I have been verbally told the following: The insurance product is not a deposit or other obligation of or guaranteed by, any bank or affiliate of any bank; and the insurance product is not insured by the Federal Deposit Insurance Corporation (FDIC) or any agency of the United States, the bank, or an affiliate of the bank.

I hereby authorize Blue Cross and Blue Shield of Nebraska to obtain and/or release medical or other information to the extent necessary to process my claims or for underwriting or administrative purposes. I authorize any party, including the Medicare program and its contractors, to release eligibility, claims, payment, or medical information to Blue Cross and Blue Shield of Nebraska for the same purposes. This authorization is ongoing. I understand that any false statements on this application may cause the coverage to be void.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_



**AGENT SECTION ONLY**

Agent shall list any other health insurance policies they have sold to the applicant: \_\_\_\_\_ List policies sold which are still in force. \_\_\_\_\_

List policies sold in the past five (5) years which are no longer in force. \_\_\_\_\_ Attached is Form 3205

Signature of Agent: \_\_\_\_\_ Date: \_\_\_\_\_ Agent Name (printed): \_\_\_\_\_ Agent Number: \_\_\_\_\_

**OFFICIAL USE ONLY**

Eff. Date \_\_\_\_\_ Approved \_\_\_\_\_ Date \_\_\_\_\_ Rejected \_\_\_\_\_ Date \_\_\_\_\_