Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: fax:

Step 2

SELECT THE TYPE OF BILLING YOU WANT – Monthly

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Blue Shield of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...

Blue Shield of California
An Independent Member of the Blue Shield Association

FOR OFFICE USE ONLY
Accept. Code ________
Plan Type ________
Market Code ________

Application for Blue Shield of California Medicare Supplement Plans

HERE'S HOW TO APPLY

1. Provide ALL requested information and print clearly in ink.
2. Sign and date in all places indicated.
3. Within 30 days of your signature date, mail the application in the postage-paid envelope enclosed. Keep the yellow copy for your records.
4. Please submit your first payment along with your application. Blue Shield will refund your payment if your application is not approved.

If you have questions about how to enroll, please call us at **(888) 713-0000** (TDD: **(888) 595-0000**).

PERSONAL INFORMATION

First Name ________ Middle Initial ____ Last Name ________

Home Mailing Address ________

Home City ________ Home State ____ Home Zip ____

Home Telephone (____) ________ E-mail ________ Sex ☐ Male ☐ Female

Date of Birth ☐☐ - ☐☐ - ☐☐☐☐ (MONTH DAY YEAR) Language Preference ☐ English ☐ Spanish ☐ Chinese ☐ Other____

Please check the Plan Type* you are applying for: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ H ☐ I

Requested Effective Date: The ☐ 1st day or ☐ 15th day of ☐☐ - ☐☐☐☐ (MONTH YEAR)

Social Security Number ________ Medicare Number ________

I'm entitled to: Hospital (Part A) Effective Date ________ Medical (Part B) Effective Date ________

GUARANTEED ACCEPTANCE

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in Blue Shield's Guaranteed Acceptance Guide, in the box below, then attach proof of prior coverage and sign and date the sheet.

I believe I qualify for guaranteed acceptance based on situation number ☐.

C-12687-FAX (7/04)

CURRENT HEALTH PLAN INFORMATION

To the best of your knowledge do you have:

1. ☐ Yes ☐ No (a) A Blue Shield of California Medicare Supplement Plan and want to transfer to a different Blue Shield Medicare Supplement Plan?

   ☐ Yes ☐ No (b) A Medicare Supplement Plan or health maintenance organization (HMO), policy or contract (including a health care service plan contract) from a company other than Blue Shield of California?

   (c) If yes with which company? ____________________

2. ☐ Yes ☐ No If you currently have a Medicare Supplement plan, do you intend to replace your current policy or contract with a Blue Shield Medicare Supplement Plan? If so, please complete and return the Replacement of Medicare Supplement Coverage form.

3. ☐ Yes ☐ No Do you have any other health care coverage that provides benefits similar to this Blue Shield Medicare Supplement Plan?
   (a) If yes, with which company? ____________________
   (b) What kind of coverage? ____________________

4. ☐ Yes ☐ No Are you covered for medical assistance by Medi-Cal?

   ☐ Yes ☐ No (a) As a specified low-income Medicare beneficiary (SLMB)?

   ☐ Yes ☐ No (b) As a qualified Medicare beneficiary (QMB)?

   ☐ Yes ☐ No (c) For other Medi-Cal or Medicaid medical benefits?

5. ☐ Yes ☐ No Did you have Medicare coverage before age 65?
   (a) If yes, why? ____________________
   (b) What is the current status? ____________________

STATEMENT OF HEALTH

If you qualify for enrollment on the basis of guaranteed acceptance, you will not be denied coverage based on your answers below. Please answer "Yes" or "No" to each question.

1. Have you, **within the past three years,** received treatment or been hospitalized for any of the conditions listed below? If "Yes," please explain the condition and indicate date of treatment at the end of this section.

   ☐ Yes ☐ No Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, senility, Alzheimer's, paralysis, stroke, etc.

   ☐ Yes ☐ No Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.

   ☐ Yes ☐ No Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.

   ☐ Yes ☐ No Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.

   ☐ Yes ☐ No Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.

   ☐ Yes ☐ No Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy*

   ☐ Yes ☐ No Cancer or malignant tumors

   ☐ Yes ☐ No Have you, within the past three years, received treatment or been hospitalized for any other condition than those listed above?

2. ☐ Yes ☐ No Do you have a pacemaker or artificial heart valve or have you had transplant surgery or heart surgery such as angioplasty or bypass? If "Yes," please explain the condition and indicate date of treatment at the end of this section.

continued on page 3...

3. ☐ Yes ☐ No Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital or other institution **within the past three years?** If "Yes," please explain the confinement and indicate date of confinement at the end of this section.

4. ☐ Yes ☐ No Are you currently taking medication? If "Yes," please list all medications you are currently taking and the condition for which the medication is prescribed at the end of this section.

* California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

If you answered "Yes" to any of the above questions, please explain your current condition as well as dates associated with your answers. If additional space is required, please use separate sheets of paper, and sign and date each sheet.

Condition	Date	Explanation

TERMS, CONDITIONS AND AUTHORIZATIONS

Information Regarding Medicare Supplement Coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.

1. You do not need more than one Medicare Supplement plan policy or contract.
2. If you purchase a Blue Shield Medicare Supplement Plan contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement plan policy or contract.
4. The benefits and dues under your Blue Shield Medicare Supplement Plan can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your plan will be reinstated, if requested, within 90 days of losing Medi-Cal eligibility.
5. Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

Conditions of Membership:

1. This application and Statement of Health will become part of the Evidence of Coverage for which I am applying, and together with any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2. I will receive no coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3. Only Blue Shield can approve this application. I understand that any insurance agent, broker or Sales Representative cannot grant approval, change terms or waive requirements.

continued on page 4...

4. Authorization for Disclosures of Personal Information: I authorize any "provider of care," insurer or health plan to disclose to Blue Shield of California, or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding me, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review, and administrative functions reasonably related to executing and managing this Agreement. This authorization will remain valid as follows for the term of the coverage or for as long as may be necessary for processing of claims incurred during coverage. I understand that I am entitled to a copy of this application and that a photocopy is as valid as the original.

I acknowledge receipt of the Summary of Benefits, the "Guide to Health Insurance for People with Medicare" and a copy of this application. I have read the Summary of Benefits and the terms, conditions and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's Signature _______________ Date _______________

REPRESENTATIVE INFORMATION

Agent/Broker Name_______________

Agent/Broker ID _______________ Agent/Broker Phone # _______________

List all policies or plan contracts sold which are still in force:_______________

List all policies or plan contracts sold in the past five (5) years that are no longer in force:_______________

____

BILLING INFORMATION

Please include your first payment along with your application. To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement Plans Summary of Benefits and Provisions. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, Health Service Agreement and member identification card as proof of approval.

Select your payment choice: ☐ Easy$Pay℠ (automatic monthly debit – you must complete the enclosed form)
☐ Quarterly billing ☐ Monthly billing

You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Blue Shield® and the Shield symbols are registered service marks of the BlueCross BlueShield Association, an Association of Independent Blue Cross and Blue Shield plans. Easy$Pay℠ is a service mark of Blue Shield of California.