Application for
Blue Shield of California
Medicare Supplement plans

blue of california

Here's how to apply

1 Provide ALL requested information and print clearly in blue or black ink.

2 Sign and date in all places indicated.

3 Within 30 days of your signature date, please fax or mail your completed enrollment form to:
Fax: (844) 266-1850
Address: P.O. Box 3008 Lodi, CA 95241-9969

4 Please submit your first payment along with your application. Blue Shield will refund your payment if your application is not approved.

Personal information

First name	Middle initial	Last name	
Home address			
City		State	ZIP
Home telephone		Email address	
Mailing address (if different from above)			
City		State	ZIP
Billing address (if different from above)			
City		State	ZIP
Gender: ☐ Male ☐ Female		Date of birth ___ ___ – ___ ___ – ___ ___ ___ ___ Month Day Year	
Medicare number		Social Security number	

I'm entitled to: ☐ Hospital (Part A) effective date _____
☐ Medical (Part B) effective date _____

Please check the plan type you are applying for: ☐ A ☐ C ☐ D ☐ F ☐ High Deductible F ☐ K ☐ N

Requested effective date: The ☐ 1st day or ☐ 15th day of _____ – _____
Month Year

Language preference ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Medicare Prescription Drug Plan information

Have you purchased a Medicare prescription drug plan? ☐ Yes ☐ No

If Yes,

a. With what company? _____ b. What is the effective date? _____

White copy: Give to your Blue Shield agent or mail to Blue Shield's Underwriting Department with your first payment.
Yellow copy: Keep with your important Blue Shield documents and information.

Guaranteed acceptance

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

I believe I qualify for guaranteed acceptance based on situation number_____ .

If applying for guaranteed acceptance under situation No. 2 on the enclosed Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form and submit with your completed enrollment application.

Two-party contracts

You and your spouse or domestic partner may qualify for a TWO-PARTY CONTRACT. Both individuals must be age 65 or older, enrolled in both Medicare Parts A and B, and apply for the same plan type. Either person who does not qualify for guaranteed acceptance (see above) will be subject to underwriting.

Each individual must complete their own application:

If you and your spouse/domestic partner are applying for a two-party contract, please check this box: ☐

Please provide:

1. Your spouse/domestic partner's name: _____
2. Spouse/domestic partner's Social Security number or Blue Shield ID number: _____
3. Spouse/domestic partner's authorization to change their contract to a two-party contract by signing below:

   Spouse/domestic partner signature:_____ Date:_____

   Print name_____

Payment 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, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Select your initial payment choice:

- ☐ Easy$Pay℠ (automatic monthly debit from your checking or savings account – save $3 each month – you must complete the Easy$Pay authorization on the next page, even if you are currently on Easy$Pay with another Blue Shield plan)
- ☐ Check enclosed with this application
- ☐ Payment for two-party contract is included on spouse/domestic partner's application*

If you are not using Easy$Pay, please indicate how you would like to receive your paper bill going forward.

☐ Quarterly billing ☐ Monthly billing

* If you are applying for a two-party contract for you and your spouse/domestic partner and paying by check, please enclose only one check for the applicable two-party rate, which can be found in the Summary of Benefits. Easy$Pay payments will automatically be debited at the applicable two-party rate.

If you selected Easy$Pay as your monthly dues payment option, please fill out this page. If not, please skip to page 4.

Easy$Pay Authorization form

Debit date: ☐ 1st of the month ☐ 15th of the month		Type of account: ☐ Checking ☐ Savings	
Bank routing/transit number:		Bank account number:	
Name of financial institution:		Branch telephone number:	
Name(s) on bank account			
Branch address	City	State	ZIP

Authorization and signature(s)

I authorize my plan, Blue Shield of California or Blue Shield of California Life & Health Insurance Company ("Blue Shield"), to initiate debits (and/or make corrections to previous debits, as necessary) to the bank account identified on this form on the payment date, and with the frequency set forth above for the purpose of payment of the monthly dues/premium owed for myself and any family members covered by Blue Shield. I understand that charges may occur two to three days prior to the payment date indicated on this form. I also authorize my financial institution to reduce the balance of my account by the amount of such debits (and/or corrections to previous debits). I will maintain sufficient collected funds in my account for the full amount of each payment. If the automatic debit transaction ever fails (e.g., no funds are available), Blue Shield will mail a bill to me at my address on record, and I will be responsible for making my payment by check or money order, along with a returned item service charge.

Notice to change/cancel required

I will continue to be debited/charged the amount of dues/premium owed until I cancel this automatic payment authorization upon at least 10 calendar days' notice before a debit/charge is to occur. To cancel this automatic payment authorization, or if there are changes to my account being debited/charged, I must contact Customer Service at **(800) 248-2341** [TTY (800) 241-1823].
Blue Shield may cancel this authorization at any time upon notice to me.

By signing below, I agree to the terms and conditions of this authorization form, and I acknowledge that I have received a copy of this form (if the bank account is a joint account, all account holders must sign). I acknowledge that all payment transactions must comply with the provisions of U.S. law. I will make payments by check or money order until my automatic payment service has been activated.

Account holder signature	**Print name**
Social Security number	**Date**
Signature	**Print name**
Social Security number	**Date**

Current insurance coverage information (required for all submissions)

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 contract, or that you had certain rights to buy such a contract, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance. **Please include a copy of the notice from your prior insurer with your application.**

Please answer all questions to the best of your knowledge. (Please mark Yes or No below with an X.)

1 ☐ Yes ☐ No a. Did you turn 65 years of age in the last 6 months?

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

c. If yes, what is the effective date? _____

2 ☐ Yes ☐ No Are you covered for medical assistance through California's Medi-Cal program?
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

If Yes,

☐ Yes ☐ No a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?

☐ Yes ☐ No b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

3 ☐ Yes ☐ No 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 the "END" blank.

Start _____ Carrier name: _____ Plan type: _____

End _____ Reason for coverage ending: _____

If Yes,

☐ Yes ☐ No b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?

☐ Yes ☐ No c. Was this your first time in this type of Medicare plan?

☐ Yes ☐ No d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?

4 ☐ Yes ☐ No a. Do you have another Medicare Supplement plan policy or certificate or contract in force?

b. If so, with what company? _____ What plan do you have? _____

☐ Yes ☐ No c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract?

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

a. If so, what companies and what kind of policy?

Carrier name: _____ Carrier phone No.: _____

Plan type: _____ Current ID No.: _____

b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "END" blank.) Start _____ End _____

6 ☐ Yes ☐ No Are you under age 65?

If Yes, a. Do you have end-stage renal disease? ☐ Yes ☐ No

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.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-HMO-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's Internet website (www.dmhc.ca.gov).

Terms, conditions, and authorizations

Information regarding Medicare Supplement plan 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 this 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 or Medicaid, and may not need a Medicare Supplement plan contract.

4 If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5 If you are eligible for, and have enrolled in, a Medicare Supplement plan contract 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 plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6 Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan 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). You may obtain information regarding counseling services from the State Department of Aging.

Conditions of membership

1 This application and the Statement of Health, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.

2 I will not receive 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.

4 I acknowledge receipt of the Summary of Benefits and a copy of this application. I have read the Summary of Benefits and the terms, and conditions of coverage set forth above. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided.

Applicant's signature	**Date**

Producer information – Must be completed by producer

Producer number	Telephone number ☐ Update	Fax number ☐ Update
	805-544-6454	805-544-8096

Producer name
Susan Polk

Email address ☐ Update
service@susanpolk.com

Producer address ☐ Update
1443 Marsh Street

City	State	ZIP
San Luis Obispo	CA	93401

Section 1 – Please list any other health insurance policies or plan contracts sold to the applicant as follows:

List policies and plan contracts sold that are still in force: _____

_____

List policies and plan contracts sold in the past five years that are no longer in force: _____

_____

Section 2 – If the applicant did not complete the Statement of Health section (is guaranteed acceptance), you do not need to complete this section.

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

Review and select one of the following:

☐ I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

☐ I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

Super Producer name	Super Producer number

Today's date (required)	**Producer's signature (required)**	**Print name**

Notice: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Statement of health

Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided.

If you qualify for guaranteed acceptance, do not complete this section. (See the Guaranteed Acceptance section for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

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 the date of treatment at the end of this section.

- ☐ Yes ☐ No a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
- ☐ Yes ☐ No b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
- ☐ Yes ☐ No c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
- ☐ Yes ☐ No d. Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.
- ☐ Yes ☐ No e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
- ☐ Yes ☐ No f. 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 g. Cancer or malignant tumors.
- ☐ Yes ☐ No h. Have you 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 the date of treatment at the end of this section.

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 the date of confinement at the end of this section.

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

5 ☐ Yes ☐ No Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

Condition or medication	Date	Explanation/current status

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

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

Signature†	**Date**

† Your signature is required in this section only if completing the Statement of Health.

Authorization for release of medical information

By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

If you qualify for guaranteed acceptance, do not sign this release. (See the Guaranteed Acceptance section for qualifying information.)

Signature	**Date**

Dental PPO plans

Affordable dental plans and dental + vision package for Medicare Supplement plan members.

Please see the *Blue Shield Dental plans and dental + vision package* flier in this enrollment kit for more information.

To sign up for Blue Shield dental coverage, select a plan below:

Dental plan options (check one):

☐ Specialty Duo dental + vision package*

☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

Conditions of coverage

- Dental benefits aren't subject to any health plan deductible requirements.
- If your dental or dental + vision coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reinstatement, but you will have to wait 6 months to reapply.

For two-party enrollment

If you are enrolled in a Medicare Supplement plan with a two-party contract, you may enjoy the convenience of a single bill and lower rates for you and your spouse/domestic partner. Keep the same convenience when you choose your dental plan by matching your dental PPO plan or dental + vision package enrollment with your Medicare Supplement plan enrollment. You and your spouse/domestic partner need to select and both enroll in the same dental PPO plan or dental + vision package in order to receive one bill that combines Medicare Supplement plan and dental PPO plan or dental + vision package rates. If only one of you wants to enroll in a dental PPO plan or dental + vision package, or if you each want different dental PPO plans or dental + vision package, your two-party agreement for the Medicare Supplement plan will be affected. In order to enroll in the dental plans or dental + vision package in this way, you will need to change your two-party contract and rate to individual contracts and single-party rates.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). This plan is pending regulatory approval. Specialty Duo package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.