BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association

PLAN A

MEDICARE SUPPLEMENT CONTRACT APPLICATION

Blue Cross and Blue Shield of Alabama does not recommend the purchase of Plan A because it provides very limited benefits for your money. For example, Plan A does not cover the Medicare Part A inpatient deductible required for admission to a hospital each 60-day benefit period. When making your decision, please review our Outline of Medicare Supplement Coverage containing information about our C Plus℠ Medicare Select Plan B and Plan F.

PLEASE NOTE:

Individuals who are receiving medical assistance benefits from the Medicaid Agency, such as regular Medicaid or QMB benefits, are not eligible to purchase Plan A or any other Medicare Supplement Plan.

Individuals who are under the age of 65 and have Medicare due to End Stage Renal Disease (ESRD) may not be eligible to purchase Plan A.

Be sure to read the important disclosures listed on the back before completing this application. Please use black ink and print clearly.

Mail this application to:

Blue Cross and Blue Shield of Alabama
Attention: Plan A Applications
P.O. Box 11551
Birmingham, Alabama 35282-9722

Blue Cross and Blue Shield of Alabama
Insurance Resource Center:
1-877-278-7007
For faster processing of your application, apply online at
www.bcbsalmedicare.com.

FOR OFFICE USE ONLY	Representative Code #1:	Representative Code #2:

PERSONAL INFORMATION

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PLEASE PRINT USING UPPERCASE LETTERS: (USE BLACK INK)

○ DR. ○ MR. ○ MRS. ○ MS. ** INDICATES REQUIRED FIELDS*

LAST NAME *	FIRST NAME *
MAIDEN/MIDDLE NAME	SUFFIX (JUNIOR, SENIOR)
SOCIAL SECURITY NUMBER * __ __ __ – __ __ – __ __ __ __	☐ MALE ☐ FEMALE
ADDRESS *	
CITY *	STATE * ZIP *
DATE OF BIRTH (MM/DD/YYYY) * __ __ / __ __ / __ __ __ __	PHONE NUMBER ☐ HOME ☐ WORK ☐ CELL (__ __ __) __ __ __ – __ __ __ __
EMAIL ADDRESS *(Optional)*	

MEDICARE INFORMATION

You must have Medicare hospital (Part A) and medical (Part B) coverage to enroll in Plan A. Please copy your information from your red, white and blue Medicare Card onto the card on the right.

HEALTH INSURANCE

MEDICARE NUMBER

	EFFECTIVE DATE
HOSPITAL PART A	/ /
MEDICAL PART B	/ /

ELIGIBILITY INFORMATION

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 with an "X."**

1. Do you have the original Medicare Plan – the traditional Medicare plan offered by the federal government that lets you go to any healthcare provider who accepts Medicare? ☐ **Yes** ☐ **No**

2. 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** _____ /_____ /_____

Please attach your disenrollment letter which shows the disenrollment date from that plan.

a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ **Yes** ☐ **No**
b. Was this your first time in this type of Medicare plan? ☐ **Yes** ☐ **No**
c. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ **Yes** ☐ **No**

TO THE BEST OF YOUR KNOWLEDGE:

1. a. Did you turn 65 in the last six (6) months? ☐ **Yes** ☐ **No**

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

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

2. Are you now entitled to Medicare as a result of disability? ☐ **Yes** ☐ **No**

3. a. Do you have kidney failure, chronic renal disease or ESRD (End Stage Renal Disease)? ☐ **Yes** ☐ **No**

b. If you have been diagnosed with ESRD, have you had a kidney transplant in the last 36 months? ☐ **Yes** ☐ **No**

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

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?

Company _____ Plan # _____

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?

Company _____ Policy # _____

b. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. **START** _____ **/** _____ **/**_____ **END** _____ **/**_____ **/**_____

6. 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**

c. Are you presently living in a nursing home? ☐ **Yes** ☐ **No**

d. Are you enrolled in the Medicaid Nursing Home Program which provides an increase in your maximum monthly income to pay premiums for supplemental coverage? ☐ **Yes** ☐ **No**

7. Are you a resident of the state of Alabama? ☐ **Yes** ☐ **No**

CHOOSE YOUR EFFECTIVE DATE AND TYPE PAYMENT

MONTH	DAY	YEAR
	01	

1. Request an effective date. This is the date your Plan A becomes effective. It may not be earlier than the date this application is received by us and must be effective on the first day of the requested month.

2. Select ONE payment method. Failure to choose a payment method will delay the processing of your application. Premiums are payable in advance on a monthly basis.

☐ **E-CHECK –** Complete and mail the enclosed Automatic Payment Authorization Agreement with a blank voided check. If approved, your payment will be charged to your account. Notification will be sent to your email address you provided on this application when premium is due.

☐ **BILL ME LATER BY E-STATEMENT –** You will receive an email notification each month when your billing statement is available. A valid email address is required. Please provide your email address in the space provided on page 1 of this application.

☐ **BILL ME LATER BY MAILED BILLING STATEMENT –** You will be mailed a billing statement each month which includes an invoice to return with your premium payment.

IMPORTANT: MEMBERSHIP AGREEMENT • PLEASE READ AND SIGN

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY:

I am applying for your Plan A Contract. If you accept this application, you will send me an identification card. I understand that acceptance of this application is subject to my answers to all questions. I also understand that this application and the Contract, including all amendments, make up my entire contract with you.

If you do not accept my application, the only thing you have to do is to return any premiums I paid. You may pay providers directly for services to me. I ask my doctor, hospital, Medicare or anyone else to give all medical records of me to you. You may release those records to anyone necessary in order to administer the contract. This begins now and continues as long as you need to decide about this application and process any of my claims.

If my premiums are deducted from my pay, I authorize my employer, if applicable, to deduct the amount of premiums (or part I pay) and send them to you.

I will cooperate with you if you need information about other health policies I have, including payments by them, and I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I understand that this policy is a Medicare supplement plan and certify by my signature below that I am eligible for and enrolled in Parts A and B of Medicare. I understand and agree that Blue Cross and Blue Shield of Alabama engages in substantial interstate activity affecting interstate commerce, that this agreement itself affects interstate commerce, and that, therefore, any disagreement between us must be submitted to binding arbitration in accordance with the terms of the contract.

If I choose Plan A, I understand that for the first six months this contract will not cover any condition, disease, disorder, or ailment (including those present at birth) for which there was any medical or surgical treatment, advice, or diagnosis within 180 days prior to the effective date of this contract (unless I have completed a waiting period under any other Medicare supplement contract besides this one or I have 180 days of “creditable coverage” and enroll within 63 days after losing coverage by another health plan or meet another of the exceptions listed under the Pre-existing Condition/Limitations heading in the contract). The time I have completed under any other Medicare supplement contract shall be credited toward the 180-day waiting period required by this Contract. I also understand that Plan A provides extremely limited benefits and that Blue Cross does not recommend the purchase of this Plan A.

ACKNOWLEDGEMENT OF RECEIPT: OUTLINE OF COVERAGE

The undersigned hereby acknowledges that he/she has been given the Outline of Medicare Supplement Coverage.

ARBITRATION

THE CONTRACT YOU ARE APPLYING FOR INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT WILL BE SETTLED BY ARBITRATION — NOT A COURT. THE ARBITRATOR’S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN NOT BE REVIEWED BY A COURT; THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL. AGREEMENT TO ARBITRATE — AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE CONTRACT.

YOUR SIGNATURE _____ DATE SIGNED _____

This application is not complete unless it is signed and dated. The application MUST be fully completed before we may determine your eligibility.

THE FOLLOWING INFORMATION IS REQUIRED BY FEDERAL REGULATIONS

Please be aware that:

1. You do not need more than one Medicare supplement policy.

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

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. 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 reinstituted 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 reinstituted policy 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 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 reinstituted 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 reinstituted policy 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 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).

7. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution, fines, or confinement in prison, or any combination thereof.