



801 Pine Street
Chattanooga, TN 37402
bcbst-medicare.com

Use
Black Ink
Only

BlueCross65SM Subscriber Application

- CONFIDENTIAL -

Plan Use Only

Rec: _____

SECTION 1 - Personal Information

Applicant: Male Female

Last Name

JR, SR, etc.

First Name

MI

Social Security No.

Address (P.O. Box is not acceptable – Please provide place of residence)

City (Please do not abbreviate)

State

Zip Code

Daytime Phone

T N

Mailing Address If Different (P.O. Box is acceptable)

City (Please do not abbreviate)

State

Zip Code

Email Address

Date of Birth (mmddyyyy)

Fill in these boxes so they match your red, white, and blue Medicare card:

Medicare Claim Number:

Medicare Part A (Hospital) Effective Date (mm/dd/yyyy):

Medicare Part B (Medical) Effective Date (mm/dd/yyyy):

You must have Medicare Part A and Part B to join a BlueCross65 plan.

We cannot consider this application complete until you have given us this information.

SECTION 2 - Benefit Section - To receive benefits, you must be enrolled in Medicare Part A and Part B

I am applying for the type of BlueCross65 coverage checked below:

Desired Effective Date:

I ask to:

Check Only One Box

Plan A Plan B Plan C Plan D Plan E

Plan F Plan G Plan K Plan L

(m m d d y y y y)

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Become a Subscriber

Change my BlueCross65 Plan

SECTION 3 - Payment Information

I wish to make my payments:

Monthly Automatic Bank Draft (Complete the automatic bank draft authorization form)

Credit Card (Complete the credit card authorization form)

Applicant Last Name

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First Name

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MI

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Social Security No.

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SECTION 4 – Health Questions - Do not answer these questions if your Medicare Part B is effective within six months prior to this application.

For each question answered "YES," **circle** the applicable condition.

Yes No

1. Within the past **10 years**, have you been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?
2. Do you now have or within the past **5 years** have you had or been advised to have treatment, surgery or to take prescription medication for:
- a. Cancer (excluding basal or squamous cell), Hodgkin's disease, leukemia, or melanoma; even if the conditions are in remission?
- b. Congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder, heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement?
- c. Uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?
- d. Emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?
- e. Paget's disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?
- f. Mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy, myasthenia gravis, Parkinson's disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?

Applicant Last Name

Grid for Applicant Last Name

First Name

Grid for First Name

MI

Grid for MI

Social Security No.

Grid for Social Security No.

SECTION 5 – Current or Previous Health Insurance

To the best of your knowledge:

Yes No

Are you covered by or have you applied for TennCareSM (or Medicaid), the State/Federal program for the categorically indigent?

Do you have another Medicare supplement policy or certificate in force (including health care service contracts, health maintenance organization contracts)? If so, with what company?

Text box for Medicare supplement company name

Do you have or have you had any other health insurance policy within the last 63 days?

(a) If so, with what company?

Text box for other health insurance company name

Company Phone No.:

Grid for Company Phone No.

(b) What kind of policy (i.e., group, Medicare Advantage, etc)?

Text box for policy type

(c) What is/was your policy number?

Text box for policy number

(d) Effective Date (mm/dd/yyyy):

Grid for Effective Date

Termination Date (mm/dd/yyyy):

Grid for Termination Date

Is this policy still in effect? Yes No

Termination Reason:

Text box for Termination Reason

If the answer to either of the above questions is "Yes," do you intend to replace these medical or health policies with the BlueCross65 plan you applied for?

