of Tennessee

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

Use Black Ink Only

BlueCross65 *Select* 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

State: 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 Select 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 *Select* coverage checked below: ***Check Only One Box***

☐ Select Plan C ☐ Select Plan F

Desired Effective Date: (m m d d y y y y)

2 0

I ask to:

☐ Become a Subscriber

☐ Change my BlueCross65 *Select* 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 | First Name | MI | Social Security No.

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 | First Name | MI | 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 TennCare℠ (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?

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

(a) If so, with what company?

Company Phone No.:

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

(c) What is/was your policy number?

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

Termination Date (mm/dd/yyyy):

Is this policy still in effect? ☐ Yes ☐ No

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?

Applicant Last Name | First Name | MI | Social Security No.

SECTION 6 – Disclosure Information - Please read carefully and sign below

- You do not need more than one Medicare supplement policy.
- If you purchase this policy you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under TennCare℠ (or Medicaid) and may not need a Medicare supplement policy.
- The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under TennCare℠ (or Medicaid) for 24 months. You must request this suspension within 90 days of becoming eligible for TennCare℠ (or Medicaid). If you are no longer entitled to TennCare℠ (or Medicaid), your policy will be reinstated, if requested within 90 days of losing TennCare℠ (or Medicaid) eligibility.
- Counseling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning TennCare℠ (or Medicaid).

I acknowledge receipt of the following provisions, restrictions, and limitations of the Medicare Select Program:

1) Outline of Coverage;
2) Description of the Restricted Network Provisions including:
   a) description (including address, phone numbers and hours of operation) of the network hospitals;
   b) payments for deductibles and coinsurance when hospitals other than network hospitals are utilized;
   c) coverage for emergency and urgently needed care and other out-of-service area coverage;
   d) limitations on referral to restricted network hospitals;
   e) description of my rights to purchase any other Medicare supplement contract offered by BlueCross BlueShield of Tennessee;
   f) BlueCross BlueShield of Tennessee's Quality Assurance Program; and
   g) BlueCross BlueShield of Tennessee's Grievance Procedure;

I have received full and fair disclosure of the information described above.

Applicant's Signature: _____ **Date (mm/dd/yyyy):** 20

I am applying for the BlueCross65 *Select* coverage I have checked. I understand and agree that:

- The policy will not pay benefits for stays beginning or medical expenses incurred during the first six months of coverage, if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within six months prior to the insurance effective date.
- I will have the right to examine the policy. If its terms and conditions are not acceptable to me, I can cancel the policy within thirty (30) days after I receive it. BlueCross BlueShield of Tennessee will refund any premiums I have paid, less any benefits provided.
- The premiums for the BlueCross65 *Select* coverage I have selected will be based on my age at the time my application is approved. The premiums will be adjusted annually based on my age.
- BlueCross BlueShield of Tennessee can rely on the statements made on this application. These statements are true and complete to the best of my knowledge, information and belief.
- Any policy issued to me shall be binding only if the statements included in this application accurately represent the condition of my present health.
- If medical records from any doctor, hospital or other provider of treatment are required, I must sign a separate authorization and I must pay all fees related to obtaining the records.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

Applicant's Signature: _____ **Date (mm/dd/yyyy):** 20

I certify that I have truly and accurately recorded on this application the information supplied by the applicant.

Agent's Signature: _____ Date (mm/dd/yyyy): 20 Agent ID #:

Agent's Name (Please Print): _____ Arrangement Code: - - -

Agent's Email Address: