BlueCross BlueShield of Tennessee
801 Pine Street
Chattanooga, Tennessee 37402-2555
www.bcbst.com

Notice Regarding Replacement of Medicare Supplement Insurance

Please read this notice carefully if you intend to terminate your existing Medicare supplement insurance and replace it with a policy to be issued by BlueCross BlueShield of Tennessee, (Issuer). Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you have now. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Please sign and return the white copy with your application. Please retain the pink copy for your files.

Statement To Applicant By Issuer

1. State law provides that your replacement policy may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The Issuer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent under the original policy.
2. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Issuer to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed, and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present coverage until you have received your new policy and are sure that you want to keep it.

Applicant's Signature: X______________________________________**Date:** ___________________

Statement To Applicant By Agent

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

- ❑ Additional benefits
- ❑ Disenrollment from Medicare Advantage Plan
- ❑ Fewer benefits and lower premium
- ❑ No change in benefits, but lower premiums
- ❑ Current Plan has outpatient prescription drug coverage and enrolled in Medicare Part D.
- ❑ Other. Please specify: ____

Agent's Signature: X______________________________________

Typed Name and Address of Agent: ____

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Copy Distribution: White - BlueCross BlueShield of Tennessee Yellow - Agent Pink - Customer

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