of Tennessee
1 Cameron Hill Circle, Ste 27
Chattanooga, TN 37402
bcbstmedicare.com

Subscriber Enrollment Application

- Confidential -
Use Black Ink Only

BlueElite℠

Group No: 123776
PHC

SECTION 1 – APPLICANT PERSONAL INFORMATION

Last Name | Jr., Sr., etc. | First Name | MI

Sex: ☐ Male ☐ Female

Date of Birth (mm/dd/yyyy)

Social Security Number

Address (P.O. Box is NOT sufficient – Please provide place of residence)

City (Please do not abbreviate) | State | ZIP

County of Residence

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

City (Please do not abbreviate) | State | ZIP

Daytime Phone

Email Address

In the event a policy is issued, by giving your email address, you agree to get all communications related to this policy in electronic form from BlueCross BlueShield of Tennessee, Inc. (BlueCross). This includes information that is available now or that becomes available while you have your policy. And it includes details about the benefits provided, your relationship with BlueCross, etc. Email communications are not secure. That means there is a chance that information included in these emails can be taken and read by someone else. By entering your email address, you accept the risks associated with emailing.

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

Medicare 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 BlueElite plan.

I am applying for the type of BlueElite coverage checked below (Check Only One Box):

☐ Plan **A** ☐ Plan **D** ☐ Plan **G** ☐ Plan **N**

Only applicants first eligible for Medicare before Jan. 1, 2020 may purchase plans C or F.

☐ Plan **C** ☐ Plan **F**

Desired Effective Date (mm/dd/yyyy):

2 0

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SECTION 2 – HEALTH QUESTIONS

If you are applying during a Medigap Open Enrollment Period or a Guaranteed Issue Period (refer to "Choosing a Medigap Policy" at **bcbstmedicare.com/medigap** for clarification), SKIP SECTION 2 and GO TO SECTION 3.

Have you used tobacco in any form (including but not limited to e-cigarettes, vapes, etc.) in the past 12 months? ☐ Yes ☐ No

Do any of the following questions apply to you?
☐ Yes ☐ No If you answered "Yes," the applicant does not qualify for this insurance.
BlueCross may take steps to verify your responses.

1. Within the past **ten (10) years**, have you been treated for or had a medical provider diagnose you with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?
2. Within the past five **(5) years**, have you been treated for or had a medical provider diagnose you with or recommend treatment, surgery or prescription medicine 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 (also called CHF), coronary artery disease, angina, peripheral vascular disease, circulatory disorder (excluding high blood pressure), heart disease, enlarged heart, transient ischemic attack (TIA), stroke, heart or heart valve surgery, angioplasty, coronary bypass, pacemaker, defibrillator or stent placement?
   c. Blood disorders such as hemophilia, blood clots or anemia requiring repeated blood transfusion or any other blood disorder?
   d. Uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison's disease, liver disease, kidney failure, nephritis, hepatitis, renal insufficiency or kidney dialysis or gangrene?
   e. Emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?
   f. Paget's disease, rheumatoid or disabling arthritis, lupus, osteoporosis with fracturing, or other bone or connective tissue disorder?
   g. Mental or nervous disorder requiring treatment, organic brain disorder, Alzheimer's disease, ALS (Lou Gehrig's disease), muscular dystrophy (MD), myasthenia gravis, Parkinson's disease, multiple sclerosis (MS), cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders, or alcohol or drug abuse?
3. Within the past **two (2) years** have you been admitted to a hospital three (3) or more times?
4. Are you permanently living in a nursing facility, permanently bedridden or using a wheelchair?

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SECTION 3 – CURRENT OR PREVIOUS HEALTH INSURANCE

If you lost or are losing other health insurance coverage and got a notice from your old 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 below with an "X"]

To the best of your knowledge:

1. a. Did you turn age 65 in the last 6 months?
   ☐ Yes ☐ No
   b. Did you enroll in Medicare Part B in the last 6 months?
   ☐ Yes ☐ No
   c. If yes, what is the effective date? _____
2. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No
   [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.]
   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
3. 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 "End Date" blank.
   Beginning Date (mm/dd/yyyy): _____ End Date (mm/dd/yyyy): _____
   b. 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
   c. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
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? _____
   c. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
   If "Yes", please attach a copy of the Replacement Notice included in your enrollment package.
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? _____
   b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End Date" blank.)
   Beginning Date (mm/dd/yyyy): _____End Date (mm/dd/yyyy): _____
   c. Was the loss of coverage voluntary? ☐ Yes ☐ No

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SECTION 4 – PAYMENT INFORMATION

Please select a Premium payment option.

☐ Bill me ☐ Automatic Bank Draft If you chose automatic bank draft, please complete the form below.

Automatic Bank Draft Authorization

***CONFIDENTIAL** COMPLETELY FILL OUT THIS FORM ONLY FOR AUTOMATIC BANK DRAFT PAYMENT*

Name of Bank: _____

City: _____ State: _____ ZIP: _____

Name on Bank Account: _____ ☐ Checking ☐ Savings

Bank Routing Number:

Bank Account Number:

You may cancel your automatic bank draft any time by sending us written notice. To avoid a disruption in service, please send your request at least 30 days before your payment is due. If you have questions about your bank draft, please call 1-800-725-6849.

BlueCross subscribers will be charged a $50 fee to reinstate a medical policy that is terminated for non-payment. In addition, subscribers will be charged a Return Item Fee for payments not honored by their financial institution.

Section 5 – Disclosure Information

Please read with care and sign below.

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to review the health coverage you have and decide if you need another plan.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- If you become eligible for Medicaid later, you can ask for the benefits and premiums under your Medicare Supplement policy to be suspended for 24 months while you get Medicaid benefits. You must ask for this suspension within 90 days of becoming eligible for Medicaid. If you no longer have Medicaid, you can ask for your suspended Medicare Supplement policy to be re-instituted. If the policy you had is no longer available, you will get a similar policy. You must ask for this 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 re-instituted policy will not have outpatient prescription drug coverage. Other than that, it will be similar to what you had before the date of the suspension.
- If you have enrolled in a Medicare Supplement policy because of an eligible disability and you later are covered by an employer or union-based group health plan, you can ask for the benefits and premiums of your Medicare Supplement policy to be suspended while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy and later lose your employer or union-based group health plan, you can ask for your suspended Medicare Supplement policy to be re-instituted. If the policy you had is no longer available, you will get a similar policy. You must ask for this 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 re-instituted policy will not have outpatient prescription drug coverage. Other than that, it will be similar to what you had before the date of the suspension.
- 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).

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SECTION 5 – DISCLOSURE INFORMATION *CONTINUED*

Please read with care and sign below.

I am applying for the BlueElite 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 considered a pre-existing condition. A condition is considered pre-existing if medical advice was given or treatment recommended by or received from a provider within six months prior to the insurance effective date. Some or all of this waiting period can be waived if you have creditable coverage. Refer to the Outline of Coverage for more details.

– 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 will refund any premiums I have paid, less any benefits provided.

– The premiums for the BlueElite coverage I have selected will be based on the premiums shown in the Outline of Coverage.

– BlueCross can rely on the statements made on this application. These statements are true and complete to the best of my knowledge, information and belief.

– I have received an Outline of Coverage for the policy I applied for and shown where to access the "Choosing a Medigap Policy" guide.

– Any policy issued to me shall be binding only if the statements 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.

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.

I authorize BlueCross BlueShield of Tennessee, Inc. to draft the checking or savings account listed above for payment of health insurance premiums related to the policy identified on this form. I agree that BlueCross BlueShield of Tennessee, Inc's rights for each such draft will be the same as if it were a check made payable to BlueCross BlueShield of Tennessee, Inc. and signed by me. This authorization is valid until I provide written notice of cancellation to BlueCross BlueShield of Tennessee, Inc. I further agree that if any draft is dishonored, with or without cause, whether intentionally or inadvertently, BlueCross BlueShield of Tennessee, Inc. will have no liability even though such dishonor may result in the cancellation of health coverage or payment of a $25 non-sufficient funds fee. I attest that any payments made pursuant to this authorization are made in accordance with BlueCross BlueShield of Tennessee, Inc.'s Payments of Member Premiums by Non-Profit Organizations policy located at bcbst.com.

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

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): 2 0

Agent's Name (Please Print): _____ Agent's ID Number: _____

Agent's Email Address: _____