

**- Confidential -
 Use Black Ink Only**

**ID: _____
 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 Code _____

County of Residence _____

Mailing Address If Different (P.O. Box IS sufficient) _____

City (Please do not abbreviate) _____ State _____ Zip Code _____

Daytime Phone _____

Email Address _____

In the event a policy is issued, by providing your email address you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits contemplated under this policy, your relationship with BlueCross BlueShield of Tennessee, etc., in electronic form from BlueCross BlueShield of Tennessee. Email communications are not secure, so there is a possibility that information included in these emails can be intercepted 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 C Plan D Plan F Plan G Plan N

Desired Effective Date (mm/dd/yyyy): _____

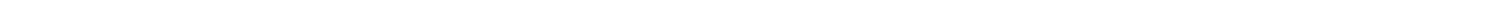
Last Name	Jr., Sr., etc.	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Social Security Number

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” for clarification), SKIP SECTION 2 and GO TO SECTION 3.

Have you used tobacco in any form 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.

1. Within the past **ten (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. Within the past **five (5) years**, have you been treated for or diagnosed by a medical professional or been advised by a medical professional 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, angina, peripheral vascular disease, circulatory disorder (excluding high blood pressure), heart disease, enlarged heart, transient ischemic attack, 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, myasthenia gravis, Parkinson’s disease, multiple sclerosis, 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 confined to a nursing facility, permanently bedridden or confined to a wheelchair?

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

Social Security Number

SECTION 3 – CURRENT OR PREVIOUS HEALTH INSURANCE

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 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

Last Name	Jr., Sr., etc.	First Name	MI
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Social Security Number			
<input type="text"/>			

SECTION 5 – DISCLOSURE INFORMATION *CONTINUED*

Please read carefully 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 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 BlueElite coverage I have selected will be based on the premiums shown in the “Outline of Coverage.”
- 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.
- I have received an Outline of Coverage for the policy I applied for and a “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 to draft the checking or savings account listed above for payment of health insurance premiums related to the subscriber ID/policy identified on this form. I agree that BlueCross BlueShield of Tennessee’s rights for each such draft will be the same as if it were a check made payable to BlueCross BlueShield of Tennessee and signed by me. This authorization is valid until I provide written notice of cancellation to BlueCross BlueShield of Tennessee. I further agree that if any draft is dishonored, with or without cause, whether intentionally or inadvertently, BlueCross BlueShield of Tennessee 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’s Payments of Member Premiums by Non-Profit Organizations Policy located at bcbst.com.

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

* Does not apply if you are applying during a Medigap Open Enrollment or Guaranteed Issue period.

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: _____

NONDISCRIMINATION NOTICE

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries Security Care, Inc. and Volunteer State Health Plan of Tennessee, Inc. also doing business as BlueCare Tennessee, complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BlueCross does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

BlueCross:

- + Provides free aids and services to people with disabilities to communicate effectively with us, such as: (1) qualified interpreters and (2) written information in other formats, such as large print, audio and accessible electronic formats.
- + Provides free language services to people whose primary language is not English, such as: (1) qualified interpreters and (2) written information in other languages.

If you need these services, contact Member Service at the number on the back of your Member ID card or call 1-800-831-2583 (TTY: 711). From Oct. 1 to March 31, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From April 1 to Sept. 30, you can call us Monday through Friday from 8 a.m. to 9 p.m. ET. Our automated phone system may answer your call outside of these hours and during holidays.

If you believe that BlueCross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance ("Nondiscrimination Grievance"). For help with preparing and submitting your Nondiscrimination Grievance, contact Member Service at the number on the back of your Member ID card or call 1-800-831-2583 (TTY: 711). They can provide you with the appropriate form to use in submitting a Nondiscrimination Grievance. You can file a Nondiscrimination Grievance in person or by mail, fax or email. Address your Nondiscrimination Grievance to: Nondiscrimination Compliance Coordinator; c/o Manager, Operations, Member Benefits Administration; 1 Cameron Hill Circle, Suite 0019, Chattanooga, TN 37402-0019; (423) 591-9208 (fax); Nondiscrimination_OfficeGM@bcbst.com (email).

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD), 8:30 a.m. to 8 p.m. ET. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

MULTI LANGUAGE SERVICES

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-553-8158 (TTY: 711).

اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-553-8158-1 (رقم هاتف الصم والبكم: 1-800-553-8158). ملحوظة: إذا كنت تتحدث اذكر

注意: 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-553-8158 (TTY:711)。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-553-8158 (TTY:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-553-8158 (TTY: 711) 번으로 전화해 주십시오.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-553-8158 (ATS : 711).

ໂປດຊາບ: ຖ້າ ວ່າ ທ່ານ ຈຶ່ງ ພາ ສາ ລາ ວ, ການ ບໍ ລິ ການ ຊ ວ ຍ ທ ັ ງ ຊ ັ ດ ງ ນ ພ ັ ສ ງ, ໂດຍ ບ ສ ບ ື ຄ ັ ງ, ຄ ມ ນ ມ ພ ັ ງ ອ ມ ທ ັ ງ ທ ັ ງ. ໂທ ຣ 1-800-553-8158 (TTY: 711).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶቻችን በነጻ ሊያግዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ 1-800-553-8158 (መስማት ለተሳናቸው: 711)።

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-553-8158 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-800-553-8158 (TTY: 711)

注意事項: 日本語を話される場合、無料の言語支援をご利用いただけません。800-553-8158 (TTY:711) まで、お電話にてご連絡ください。

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-553-8158 (TTY:711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-553-8158 (TTY: 711) पर कॉल करें।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-8800-553-8158 (телетайп: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با تماس بگیرید. 1-800-553-8158 (TTY:711)

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-553-8158 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-553-8158 (TTY: 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-800-553-8158 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-553-8158 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hólq, kojí' hódíłnih 1-800-553-8158 (TTY: 711).

