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

Subscriber Enrollment Application

- Confidential -
Use Black Ink Only

BlueElite℠

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 **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):

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

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

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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

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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 BlueShield of Tennessee 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 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 Medicaid and may not need a Medicare supplement policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be re-instituted if requested 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, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be re-instituted if requested 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, but will otherwise be substantially equivalent to your coverage 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).

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

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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 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).

– 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 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): _____

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: _____

of Tennessee

NONDISCRIMINATION NOTICE

BlueCross BlueShield of Tennessee (BlueCross), including its subsidiaries SecurityCare of Tennessee, Inc. and Volunteer State Health Plan, 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 1-800-553-8158 (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 1-800-553-8158 (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.

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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 1-800-553-8158 (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 ເວົ້າ ພາສາ ລາວ, ການ ບໍລິ ການ ຊ່ວຍ ເຫຼືອ ດ້ານ ພາສາ, ໂດຍ ບໍ່ ເສັ ຽ ຄ່າ, ແມ່ ນ ພ້ ອມ ໃຫ້ ທ່ ານ. ໂທ 1-800-553-8158 (TTY: 711).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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す。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 1-800-553-8158 تماس بگیرید. (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'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-553-8158 (TTY: 711).