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

Subscriber Change Form

- Confidential -
Use Black Ink Only

BlueElite℠

Group No: 123776
PHC

Subscriber Last Name _____ Subscriber First Name _____ MI ___

Group Number _____ Subscriber Identification Number _____ Date of Birth (mm/dd/yyyy) _____

SECTION 1 – I WANT TO:

❑ **Change my name:** Effective Date (mm/dd/yyyy) _____

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

Reason for Name Change _____

❑ **Change my address:** Effective Date (mm/dd/yyyy) _____

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

_____

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.

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

Subscriber Identification Number

SECTION 1– CONTINUED

❑ **Change my plan:** Effective Date (mm/dd/yyyy) _____

I am currently enrolled in Plan ____

I would like to change my plan to:

❑ 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

Note: Depending on the new plan you choose, you may need to answer the health questions in Section 2. To find out, look at the chart below. Find your current plan in the far left column. Then look to see if there is a "Y" or "N" under the new plan you are choosing. A "Y" means, "Yes", you will need to answer the health questions. An "N" means, "No", you do not need to answer health questions.

Examples: If you are in Plan A and you want to change to Plan G, you will need to answer health questions. If you are in Plan D and you want to change to Plan A, you will not need to answer health questions.

		New Plan					
		A	**C***	**D**	**F***	**G**	**N**
Current Plan	**A**	-	Y	Y	Y	Y	Y
	C	N	-	N	Y	Y	N
	D	N	Y	-	Y	Y	N
	F	N	N	N	-	Y	N
	G	N	Y	N	Y	-	N
	N	N	Y	Y	Y	Y	-

***Note: Only applicants who were first eligible for Medicare before January 1, 2020 may change to Plan C or F.**

❑ **Cancel my policy** Effective Date (mm/dd/yyyy) _____

❑ **Suspend this policy due to Medicaid eligibility** Effective Date (mm/dd/yyyy) _____

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

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SECTION 2 – HEALTH QUESTIONS

Complete this section if you are choosing to change to a new plan that requires you to answer health questions.

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 answer "Yes", you do 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 (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?

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

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SECTION 3 – 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).

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.

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): _____

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

Agent's Email Address: _____