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

Subscriber Change Form

- Confidential -

Use Black Ink Only

BlueElite℠

ID: _____
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 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.

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 C ❑ Plan D ❑ Plan F ❑ Plan G ❑ Plan N

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 F, you will need to answer health questions. If you are in Plan C and you want to change to Plan A, you will not need to answer health questions.

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

❑ 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

Subscriber Identification Number

SECTION 2 – Health Questions

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

Do any of the following questions apply to you?

❑ Yes ❑ No If you answer "Yes", you do 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

Subscriber Identification Number

SECTION 3 – 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).

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.

Signature: _____ Date (mm/dd/yyyy): 2 0

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 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 Security Care, Inc. and Volunteer State Health Plan, Inc. also doing business as BlueCare, 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 Feb. 14, you can call us 7 days a week from 8 a.m. to 9 p.m. ET. From Feb. 15 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.

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: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິ ການຊ່ ວຍເຫ ຼືອ ດ້ ານພາສາ, ໂດຍບ ໍ ເສ ັ ດ ຄ່ າ, ແມ ່ ນ ພ ້ ອມໃຫ ້ ທ ່ าน. ໂທຣ 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).

સૂચના: 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 . 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'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíílnih 1-800-553-8158 (TTY: 711).