

APPLICATION FOR

# SeniorBlue<sup>®</sup>

## Medicare Supplement



An Independent Licensee of the Blue Cross and Blue Shield Association

### Instructions for completing this application

To ensure complete and accurate processing of your application, **PLEASE:**

- Complete all applicable sections
- Use **BLACK PEN**

### Checklist:

- Did you indicate the benefit plan for which you are applying?
- If you want your premium automatically deducted from your checking account, have you included a voided check?
- Have you marked “YES” or “NO” to each health question (if applicable)?
- If you made any changes to this application, did you initial that change?
- Have you signed and dated the application?

## A. MEMBERSHIP INFORMATION

FB Member #	FB County #	Group Billing Unit	Monthly Premium	Policy Effective Date ____/____/____
Name (First, Middle, Last)		My Social Security No.		
Mailing Address				Apt. #
City		State	Zip Code	County #
Billing Address		City	State	Zip Code
Home Phone No. ( )		Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Are you a resident of Iowa? <input type="checkbox"/> NO <input type="checkbox"/> YES	Is this application for reinstatement of a policy which lapsed due to nonpayment of premium? <input type="checkbox"/> NO <input type="checkbox"/> YES	Is this application for reinstatement of a policy which was suspended? <input type="checkbox"/> NO <input type="checkbox"/> YES		

## B. MEDICARE INFORMATION (As shown on your Medicare ID Card)

1. Health Insurance Claim No. (Medicare ID No.): \_\_\_\_\_ Alpha Letter \_\_\_\_\_

2. Hospital Insurance (Part A) Effective Date: (month/day/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. Medical Insurance (Part B) Effective Date: (month/day/year) \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

## C. HEALTH QUESTIONS

You do not need to complete these health questions if you are applying for Plan A or for guaranteed-issue Plan C or if you are applying during the six-month open enrollment period which begins the month you first became **both 65 or older and** were enrolled in Medicare Part B.

1. Within the last two years, have you received medical advice or prescription drugs for liver problems, internal cancer, stroke, Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis (MS)?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. Within the last two years, have you had or received medical advice or testing in preparation for heart surgery, bypass surgery or angioplasty?	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. Have you received medical treatment or prescription drugs for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) and/or tested HIV positive?	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. Do you currently use an oxygen device or require dialysis for kidney disease?	<input type="checkbox"/> YES <input type="checkbox"/> NO

**NOTE: If you are not applying during the six-month open enrollment period and answer "Yes" to questions 1, 2, 3 or 4, you are only eligible to apply for Plan A or guaranteed-issue Plan C.**

## D. CONTRACT INFORMATION

Check the Senior Blue Plan for which you are applying:

<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan E
<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan L	<input type="checkbox"/> Guaranteed-Issue C

## E. PAYMENT ARRANGEMENTS

How do you want to pay your premiums?

Account Information on File with Wellmark (Available only for those with current Wellmark individual coverage)

Direct bill, if so on what basis:  Quarterly  Semi-Annually  Annually

Automatic Account Withdrawal, if so on what basis:  Monthly  Quarterly  Semi-Annually  Annually

NOTE: All billing periods are based on a calendar year.

On what date:  1st of the Month  5th of the Month

Do you want it deducted from:  Checking-attach a voided check (If applicant is not the payor, pre-authorization form (M-5750) is needed.)

Savings-complete the pre-authorization form (M-5750)



## STATEMENTS

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 reinstated if requested within 90 days of losing your 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. 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).
7. Premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium would be for the first day of a month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium would be for January 1 through December 31 of the applicable year.

## AGREEMENT AND CERTIFICATION

My signature on this application verifies that I have received the "Senior Blue Medicare Supplement Outline of Coverage," the "Guide to Health Insurance for People with Medicare," and a completed copy of this application. My signature also verifies that I have read and understand the Statements that appear above.

My signature verifies that, to the best of my knowledge and belief, I have answered the questions on this application truthfully and completely. I understand that my coverage will not begin until Wellmark Blue Cross and Blue Shield of Iowa receives and accepts this application and applicable payment and assigns an effective date of coverage.

My signature further verifies that I understand Iowa law prohibits knowingly selling more than one Medicare supplement policy to an individual. I certify that if I currently have a Medicare supplement policy in force, I will cancel my current Medicare supplement policy upon notification of acceptance for coverage by Wellmark Blue Cross and Blue Shield of Iowa. I can request that a Wellmark Blue Cross and Blue Shield of Iowa representative review my existing policies and advise whether this Senior Blue policy will duplicate the benefits of my existing health insurance policies by calling (800) 336-0505.

My signature also verifies that I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when reasonably related to the health insurance coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records, I will give this authorization.