How to apply for a Blue Cross Blue Shield of Arizona

Medicare Supplement Plan

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

Thank you for selecting Blue Cross Blue Shield of Arizona. If you have questions, need assistance completing the application or need additional application forms, please call your health insurance broker or Blue Cross Blue Shield of Arizona (BCBSAZ) at **(888) 264-1733**.

You are eligible to apply if:

- In general, you are 65 years* of age or older; and
- You are enrolled in Medicare Parts A and B; and
- You reside in Arizona if you are applying for Senior Security; or
- You reside in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal or Santa Cruz County if you are applying for Senior Preferred.

You are <u>not</u> eligible to apply for a BCBSAZ Medicare supplement plan if:

- You are receiving or have been advised to receive kidney dialysis; you have end stage renal disease (ESRD), <u>unless you are entitled to Guaranteed Issue rights</u>, as described in Section 4. You may contact the State Health Insurance Assistance Program at (602) 542-6595, (800) 432-4040 Statewide, or TDD Line at (602) 542-6366 for information regarding plans that may be available to you if you have end stage renal disease.
- You are receiving disability benefits and are under age 65.
- You are not a resident of Arizona.
- You already have a Medicare supplement or Medicare Advantage policy and do not intend to replace it with this plan.

Here's how to apply: *Please use dark ink. (Do not use red ink.)*

1. Complete, sign and date all sections as indicated by signature boxes.
2. If you are applying for Senior Preferred Medicare Select coverage, please read the Senior Preferred subsection in the Acknowledgements.
3. If you would like the convenience of automatic withdrawal for billing purposes, be sure to complete, sign, and date the Sure Pay Authorization form in Section 10.
4. If you would like Blue Cross Blue Shield of Arizona to share your personal information with another individual (such as a spouse, child or broker), please read the instructions and complete the Confidential Information Release Form included as part of this application. **This is an optional form**.
5. Mail the entire Application form to: **Attn: Blue Cross Blue Shield of Arizona**
   P.O. Box 81049
   Phoenix, AZ 85069-1049

We will return a copy to you. **Do not send any premium**. (If your application is approved, you will be billed if a contract is issued to you.)

* You may apply during the time period when you are enrolled in Medicare Parts A and B and you are 64, if there is no more than 60 days until the 1st day of the month you turn 65.

Application for Medicare Supplement Coverage

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

1 General Information

Last Name_____ First Name_____

Mailing Address_____

City_____ State_____ ZIP_____ _____

Telephone Number (_____)_____-_____ E-mail address*_____

Date of Birth ____/____/_____ (M M/ D D / Y Y Y Y) Gender ☐ M ☐ F Social Security Number _____-_____-_____ (optional)

*If I provided an email address in this application, I agree to receive communications electronically from BCBSAZ at that email address.

Is your Billing address the same as above? ☐ **Yes** ☐ **No** If no:

Billing Street Address_____

City_____ State_____ ZIP_____ _____

Do you currently have Blue Cross Blue Shield of Arizona coverage? ☐ **Yes** ☐ **No** If yes,

Contract Holder's Name _____

BCBSAZ Identification No. _____

Medicare Number and Effective Dates. Please copy this information exactly as it appears on your Medicare Card.

Medicare Card No._____

Part A (Hospital): _____/_____/_____ (M M/ D D / Y Y Y Y) Part B (Medical): _____/_____/_____ (M M/ D D / Y Y Y Y)

Part D (Prescription Drug Plan), if applicable: _____/_____/_____ (M M/ D D / Y Y Y Y)

SPACE BELOW FOR BROKER USE ONLY		
BROKER NAME, MAILING ADDRESS AND PHONE	**BROKER ID#**	**LID#**
Michael Higgins Insurance, LLC. 3905 N. 7th Avenue #34754 Phoenix, AZ. 85067 602.405.8769	01437	

2 Your Billing Preferences

How often do you prefer to be billed?

☐ Monthly

☐ Quarterly

Please select a method of payment

☐ Sure Pay Electronic Bank Draft *Please complete the Sure Pay Authorization included with this application*

☐ Paper bill

3 Your Choice of Coverage

You are eligible to apply if: (1) You are, in general, 65 years of age or older; and (2) You are enrolled in Medicare Parts A and B; and (3) You reside in Arizona for Senior Security OR, you reside in a Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal or Santa Cruz County for Senior Preferred.

Senior Security
Available throughout Arizona

☐ Plan A
☐ Plan C
☐ Plan F
☐ Plan N

Senior Preferred (Medicare Select)
Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal and Santa Cruz counties

☐ Plan C
☐ Plan N

Your Desired Effective Date
1st day of (month)

☐ Jan	☐ May	☐ Sept
☐ Feb	☐ June	☐ Oct
☐ Mar	☐ July	☐ Nov
☐ April	☐ Aug	☐ Dec

4 Eligibility Information

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.

I. (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 new Medicare supplement policy? ☐ **Yes** ☐ **No**

If you answered "Yes" to questions I (a) and (c) above, and an agent is assisting you in purchasing this plan, be sure that your agent provides you with a completed "Notice to Applicant" form as part of this application. The Notice to Applicant form is located at the end of this application.

II. (a) Did you turn age 65 in the last 6 months **OR** will you turn 65 in the next 90 days? ☐ **Yes** ☐ **No**

(b) Did you enroll in Medicare Part B in the last 6 months? ☐ **Yes** ☐ **No**

If you answer yes to both questions in section 4. II. above, you are in your Open Enrollment period and may skip the health questions in Section 5.

III. (a) Are you covered for medical assistance through a 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**,

(b) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ **Yes** ☐ **No**

(c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

IV. (a) Did you have 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? ☐ **Yes** ☐ **No**

If yes, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START _____/_____/_____ (M M/ D D / Y Y Y Y) END _____/_____/_____ (M M/ D D / Y Y Y Y)

(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**

V. (a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.) ☐ **Yes** ☐ **No**

(b) If so, with what company and what kind of policy? _____

_____

(c) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START _____/_____/_____ (M M/ D D / Y Y Y Y) END _____/_____/_____ (M M/ D D / Y Y Y Y)

(d) Did you receive a notice of termination from your current health insurer, employer, union or individual plan? ☐ **Yes** ☐ **No**

IF YES, PLEASE INCLUDE A COPY OF THE NOTICE WITH YOUR APPLICATION.

Are you in your Medicare Supplement Open Enrollment Period or do you qualify for Guarantee Issue?

If either situation below applies to you, you may skip Section 5. Health Status Questions.

- Medicare Supplement Open Enrollment lasts for 6 months and begins on the first day of the month when you are at least age 65 and enrolled in Medicare Part B. When you are in your Open Enrollment period, you are guaranteed acceptance in a BCBSAZ Medicare supplement plan and do not need to answer the Health Status Questions that follow in Section 5. For most applicants, Open Enrollment begins at age 65. However, if you delayed enrollment in Medicare Part B because you were still working and covered under your employer's health insurance, your Medicare Supplement Open Enrollment period may not begin until you are older than age 65.
- If you lose your current health insurance, you may have a Guarantee Issue Right to a Medicare Supplement policy. If you qualify for Guarantee Issue, make sure you provide appropriate documentation and apply for coverage within required timelines.

For more details about Open Enrollment and Guarantee Issue rights, please see the CMS brochure, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," which BCBSAZ makes available with this application.

5 Health Status Questions

If you are applying during your Medicare Supplement Open Enrollment Period or you are eligible for guaranteed issue, you may skip this section and go to Section 6.

Your answers to the medical questions listed below will help determine your monthly premium. If you leave a question blank, your application will be considered incomplete and returned to you. BCBSAZ will advise you of the exact rate required for the coverage you selected after we process your application.

1. Are you receiving or have you been advised to receive kidney dialysis? ☐ **Yes** ☐ **No**
2. Are you currently diagnosed with ESRD? ☐ **Yes** ☐ **No**
3. Are you currently hospitalized or in a skilled nursing facility, long-term care facility, rehabilitation facility or nursing home? ☐ **Yes** ☐ **No**
4. Have you been recently discharged from a long-term care facility, rehabilitation facility or nursing home? ☐ **Yes** ☐ **No**
5. Have you been advised to have any type of surgery (excluding dental) that has not yet been performed? ☐ **Yes** ☐ **No**
6. Have you been advised that you need to have, or have you ever had, a transplant? ☐ **Yes** ☐ **No**
7. Within the last 5 years, have you been treated or diagnosed with any type of cancer (other than skin cancer)? ☐ **Yes** ☐ **No**
8. Within the last 5 years, have you been treated for or advised by a physician to have treatment for alcoholism or drug addiction requiring inpatient or outpatient treatment? ☐ **Yes** ☐ **No**
9. In the last 5 years, have you been hospitalized for any psychological or mental disorder(s)? ☐ **Yes** ☐ **No**
10. Have you ever been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)? ☐ **Yes** ☐ **No**
11. Have you ever been diagnosed or treated by a licensed health care provider for any of the following:
    a. Alzheimer's disease, senile dementia ☐ **Yes** ☐ **No**
    b. Rheumatoid arthritis, myasthenia gravis, lupus, multiple sclerosis, amyotrophic lateral sclerosis (ALS) ☐ **Yes** ☐ **No**
    c. Diabetes (Type I or Type II) ☐ **Yes** ☐ **No**
    d. Emphysema, chronic obstructive pulmonary disease (COPD), tuberculosis, (not including asthma) ☐ **Yes** ☐ **No**
    e. Cirrhosis, hepatitis B or hepatitis C ☐ **Yes** ☐ **No**
    f. Parkinson's disease ☐ **Yes** ☐ **No**
    g. Osteoporosis with osteoporosis related fractures ☐ **Yes** ☐ **No**
    h. Degenerative Bone Disease ☐ **Yes** ☐ **No**
    i. Congestive Heart Failure (CHF), Cardiomyopathy, Carotid Artery Disease (CAD), Peripheral Vascular Disease ☐ **Yes** ☐ **No**
    j. Heart attack or stroke (including TIA), cardiac surgery (including coronary bypass surgery or angioplasty), rhythm disorders requiring a pacemaker? ☐ **Yes** ☐ **No**

Please list the name and phone number of your physician(s). If needed, continue your list on a separate sheet of paper.

_____ (_____)_____
Treating Physician's name Phone number

_____ (_____)_____
Treating Physician's name Phone number

6 Tobacco Use

You are required to answer this question even if you are applying during your Medicare Supplement Open Enrollment Period and/or you are eligible for guaranteed issue.

Your answer to the question listed below will help determine your monthly premium rate. If you leave the question blank, your application will be considered incomplete and returned to you. BCBSAZ will advise you of the exact rate required for the coverage you selected after we process your application.

1. Have you used tobacco products in the last 12 months? ☐ **Yes** ☐ **No**

7 For Your Protection

I. You do not need more than one Medicare supplement policy.

II. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

III. You may be eligible for benefits under Medicaid* and may not need a Medicare supplement policy.

IV. If, after purchasing this policy, you become eligible for Medicaid*, the benefits and premiums under your BCBSAZ 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

V. Counseling services may be available in Arizona to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid* program, including benefits such as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

*Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program.

8 Acknowledgments – read this section and sign at the end

I. I have carefully read all of this application form and the information I provided. I understand and agree that it will be part of my contract with Blue Cross Blue Shield of Arizona (BCBSAZ).

II. I understand and agree that:

- the information I've provided is material to BCBSAZ's decision to offer health care coverage;
- BCBSAZ will rely on the accuracy of the information to determine my eligibility for coverage and the premium rate I will pay for that coverage;
- If BCBSAZ discovers a material misrepresentation or omission after issuing coverage, BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage, or adjust my premium rate to the rate I should have paid based on accurate information, retroactive to the effective date of coverage.
- coverage will be effective only after BCBSAZ has accepted and reviewed this application and assigned an effective date.
- coverage will be subject to the benefits, limitations and provisions, of the BCBSAZ benefit plan, regardless of other coverage I may have had in the past;

III. I acknowledge that I have received an Outline of Coverage for BCBSAZ's Senior Security and Senior Preferred plans.

IV. I acknowledge that I have received a copy of the "Guide to Health Insurance for People with Medicare."

V. I understand that:

- BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers.
- Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a broker.
- BCBSAZ generally pays a commission to the broker of record or permitted assignee until this contract is terminated or the contract holder terminates his/her relationship with the broker or the broker becomes ineligible.
- BCBSAZ broker contracts require the broker to give me information on the broker's commission rate with BCBSAZ. I can also get more detailed information about broker commission and compensation paid to BCBSAZ licensed inside sales representatives for sales of BCBSAZ individual products at azblue.com or by calling BCBSAZ at (602) 864-4021.

Note: If you are applying for a Senior Preferred plan, make sure to review subsection 7. (VI.) that follows before completing the signature box. If you are applying for a Senior Security plan, you may skip subsection 7. (VI.) and proceed directly to the signature box.

VI. **For Senior Preferred Applicants Only – Medicare Select Acknowledgment**

If you are applying for Senior Preferred Medicare Select Plan C or Plan N (available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal and Santa Cruz counties only), please read this section. I acknowledge that I have received the following information and understand the restrictions of the Senior Preferred benefit plan:

- An Outline of Coverage comparing the Senior Preferred Medicare Select benefit plan and premium with the Senior Security benefit plans and premiums, which includes the following:
  - A description of benefits available when Senior Preferred or non-Senior Preferred providers are used
  - A description of coverage for emergency and out-of-service-area care
  - A description of limitations on referrals to non-Senior Preferred providers
  - A description of my right to purchase a Senior Security plan
  - A description of BCBSAZ's quality assurance program and complaint and grievance procedure
- A Senior Preferred provider directory

VII. **I give permission for BCBSAZ to call me at the phone number(s) provided in this application to provide information and/or discuss matters related to any benefit plan that I purchase, as well as health and wellness information that is related to any such benefit plan.**

All applicants must sign and date the signature box below to indicate agreement with the acknowledgments.

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

9 TO BE COMPLETED BY THE AGENT: Agents shall list any other health insurance policies sold to the applicant.

I. Have you sold any other health insurance policies to the applicant, either in force or within the last five (5) years? ☐ **Yes** ☐ **No**

II. List all health insurance policies sold to the applicant that are still in force.

_____

_____

III. List all health insurance policies sold to this applicant in the past five years that are no longer in force.

_____

_____

_____

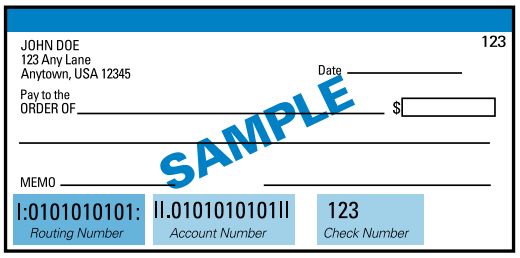
Agent's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

10 Sure Pay Authorization

Save the trouble of writing us a check. With Sure Pay, there's no bill to keep track of, no check to write, and nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account.

If the first deduction is delayed, the initial amount may be more than one monthly premium.

Electronic Billing Information



Pay your premiums the convenient way with Sure Pay

Please debit my: ☐ Checking ☐ Savings

ROUTING TRANSIT NUMBER _____

ACCOUNT NUMBER _____

To the Financial Institution

- I authorize BCBSAZ to start an automatic periodic charge to my checking or savings account as noted above. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.
- I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Sure Pay service. I agree to allow a reasonable time for discontinuation of Sure Pay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Sure Pay withdrawals.
- I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.
- I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.
- I have read and agree to abide by the Sure Pay conditions as outlined on this authorization form. I understand any applicable refund of monies due will be released 30 days after the last draft date.

Authorized signature on account _____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

Confidential Information Release Form

An Independent Licensee of the Blue Cross and Blue Shield Association

Please complete the Confidential Information Release Form if you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share your personal information with the individual or organization you specify on the form. Each individual 18 and over should complete a separate form.

This authorization is voluntary. We will not condition our claim payment activities, your enrollment in our health plan or your eligibility for benefits on you giving us this authorization.

Examples of Use

Here are a few examples for which the form may be used. Complete the form if you would like BCBSAZ to share certain or all of your personal information with:

- Another adult such as a spouse, parent, child or personal representative so they can discuss your claims or billing questions with BCBSAZ.
- Your broker during or after the enrollment process for the level of service he or she is to provide (enrollment, claims and/or billing questions, etc.)
- Your attorney for a specific legal issue that arises, such as a personal injury case.

Specific Instructions

Information to be Disclosed: Indicate the specific information you want to share (application, enrollment, eligibility, EOBs, claims, medical records, etc.)

Person Whose Information May Be Released: Enter the name of the person whose information should be disclosed. This will normally be your name.

Who May Receive the Indicated Information: Tell us who you are authorizing to receive your information.

Purpose of Use/Disclosure: Tell us why you want us to share your information.

Authority to Update My Records: Tell us if the person you indicate is authorized by you to update our records if you move to a different address, change banks or change bank accounts.

Expiration Date: This authorization will automatically expire 90 days after your last coverage date. You have the right to revoke this authorization earlier by contacting the Privacy Office.

Identification Number and Group Number: Enter your BCBSAZ ID number if you've received one; otherwise enter your social security number.

Signature: Print and sign your name and date the form.

Group Name and Number: If applicable, enter the name and number of the employer or other insured group under which you are covered.

Personal Representative: A personal representative is a legal designation and generally refers to parent of an unemancipated minor, Legal Guardian, or Holder of Power of Attorney. If you are the Personal Representative and are completing this form for someone else, please complete the last two rows and attach copies of relevant legal documents.

Confidential Information Release Form

(To authorize BCBSAZ to disclose and/or update your information)

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

You must use a separate form for the release of HIV-related information. Return this completed form with your application. Current BCBSAZ customers should mail this completed form to Blue Cross Blue Shield of Arizona, Attention: Enrollment Services, P.O. Box 13466, Phoenix, AZ 85002. Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

Information to be Disclosed: I authorize BCBSAZ to disclose the following information, including information about communicable diseases, alcohol and drug abuse treatment and genetic testing: (Please check all that apply.)

- ☐ Application, Enrollment, Eligibility Information
- ☐ Billing/Payment Information
- ☐ Claims/EOB Information
- ☐ Medical Records
- ☐ Precertification Information
- ☐ Account Information
- ☐ Other (please describe):

Person Whose Information May Be Released: _____

Who May Receive the Indicated Information:

Name: _____

Company Name: _____

Street Address: _____

City, State, Zip Code: _____

Purpose of Use/Disclosure:

- ☐ To assist with obtaining a health care policy
- ☐ To assist with claims processing and/or payments
- ☐ Other Purpose of Use/Disclosure: _____

Authority to Update My Records: I also authorize _____ to be able to:

- ☐ Change My Mailing Address
- ☐ Update My SurePay/Banking Information

Unless you revoke this authorization earlier, it will expire 90 days after the expiration or termination of your coverage with BCBSAZ. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws. **You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, Mail Stop C302, P.O. Box 13466, Phoenix AZ 85002-3466. Revocation of this authorization will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.**

Printed Name _____ Identification Number _____

Signature _____ Date (mm/dd/yyyy) _____

Group Name (if applicable) _____ Group Number (if applicable) _____

Personal Representative's Name* _____ Relationship to Individual _____

Personal Representative's Signature _____ Date (mm/dd/yyyy) _____

* Please attach a copy of the relevant legal document(s)

You are entitled to a copy of this authorization after you sign it. You may refuse to sign this authorization.

Office Copy

Please return this copy with your application

BlueCross BlueShield of Arizona

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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE COVERAGE

Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing Medicare supplement contract or Medicare Advantage insurance and replace it with a contract to be issued by Blue Cross Blue Shield of Arizona. Your new contract to be issued by Blue Cross Blue Shield of Arizona will provide thirty (30) days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this contract.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):

☐ Additional benefits. ☐ No change in benefits, but lower premiums. ☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Explain reasons for disenrollment. _____

_____

☐ Other. (Please specify) _____

If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application which requests that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new contract and are sure you want to keep it.

_____

(**Signature of Agent, Broker, or Other Representative**)

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

Customer Copy

Please keep this copy for your records.

BlueCross BlueShield of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE COVERAGE

Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

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Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):

☐ Additional benefits. ☐ No change in benefits, but lower premiums. ☐ Fewer benefits and lower premiums.

☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

☐ Disenrollment from a Medicare Advantage plan. Explain reasons for disenrollment. _____

_____

☐ Other. (Please specify) _____

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Do not cancel your present policy until you have received your new contract and are sure you want to keep it.

_____

(**Signature of Agent, Broker, or Other Representative**)

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

BlueCross
BlueShield
of Arizona

An Independent Licensee of the Blue Cross and Blue Shield Association

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