

APPLICATION FOR SUPPLEMENT TO MEDICARE



**Regence
BlueShield**
of Idaho

An Independent Licensee of the Blue Cross
and Blue Shield Association

**1602 21st Avenue • P.O. Box 1106
Lewiston, Idaho 83501
208 746-2671 • 1 800 632-2022**

PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM.

- 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 coverage.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- The benefits and rates under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medicaid for up to 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing your Medicaid eligibility.
- 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).

PLEASE PRINT. Answer all questions completely and accurately to ensure timely processing.

Name		Birth Date		Age
Address				
Telephone	<input type="checkbox"/> Male	<input type="checkbox"/> Female	Social Security Number	
Do you use Tobacco in any form?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Height	Weight

Please copy the information from your Medicare card onto the sample card at right, or attach a copy of your Medicare card, or the Letter of Verification from the Social Security Administration or Railroad Retirement Board. This information is required to process your application.

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY _____	
MEDICARE CLAIM NUMBER _____	SEX _____
IS ENTITLED TO: _____	EFFECTIVE DATE _____
HOSPITAL (PART A) _____	
MEDICAL (PART B) _____	

Coverage Applied For

- | | | |
|---------------------------------|---|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan G | <input type="checkbox"/> Senior Selection | |

_____	_____	_____
Agent #	Package #	Effective Date

TYPE OF BILLING DESIRED

- Monthly Automatic Bank Withdrawal (*authorization form will be sent to you.*)
- Standard Monthly Billing/Payment by Check
 - Requested Effective Date _____

Your policy effective date will be the first of the month following the date the application is received and approved in our office. If you want a different effective date, please indicate in the area above. The earliest possible effective date is the date the application is received in our office.

TYPE OF APPLICATION

- New
- Transferring from another BlueShield of Idaho plan.
 - Name of Plan _____
- Converting from a Regence BlueShield of Idaho group plan.
- Converting from another company.
 - Name of Company _____
 - Name/type of Policy _____
- Converting from a Regence BlueShield of Idaho individual plan.

TO THE BEST OF YOUR KNOWLEDGE...

Yes No

- Do you have another Medicare supplement policy or certificate in force?
If Yes: a. With which company? _____
b. Do you intend to replace your current Medicare supplement policy with this policy? Yes No
- Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?
If Yes: a. With which company? _____
b. What kind of policy? _____
- Are you covered for medical assistance through the state Medicaid program?
If Yes: As a "Specified Low-Income Medicare Beneficiary" (SLMB).
 As a "Qualified Medicare Beneficiary" (QMB).
 For other Medicaid medical benefits.

Authorization signature required on Page 6.

Congress has established a 6-month open enrollment period for buying Medicare supplement health insurance (Medigap). The law guarantees that for 6 months immediately following enrollment in Medicare medical coverage (Part B), individuals aged 65 or older cannot be denied Medigap insurance because of health problems.

If you are applying for coverage **within the 6 month period** immediately following your enrollment in Medicare Part B coverage, you may **skip all of the questions on pages 3 and 4** of this application concerning your medical and health history and complete pages 5 and 6.

If you are applying for coverage **after 6 months** from the time you enrolled in Medicare Part B coverage, you must complete all of the questions on this application.

**Applicant must complete and answer all questions,
or application will be returned.**

I. Are you now a patient in a hospital or in an extended care facility? Yes No

II. Indicate if you have ever suffered from, or received care for any of the following in the last 5 years.
(All spaces must be marked either yes or no.)

	Yes	No		Yes	No
1. Accident, injury, or deformity	<input type="checkbox"/>	<input type="checkbox"/>	20. Liver disorder	<input type="checkbox"/>	<input type="checkbox"/>
2. Acquired Immune Deficiency Syndrome (AIDS) or related disease	<input type="checkbox"/>	<input type="checkbox"/>	21. Lung problems	<input type="checkbox"/>	<input type="checkbox"/>
3. Alcoholism or drug dependency	<input type="checkbox"/>	<input type="checkbox"/>	22. Nervous or emotional condition	<input type="checkbox"/>	<input type="checkbox"/>
4. Anemia or blood disease	<input type="checkbox"/>	<input type="checkbox"/>	23. Neurological disease	<input type="checkbox"/>	<input type="checkbox"/>
5. Arthritis, Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	24. Neuritis	<input type="checkbox"/>	<input type="checkbox"/>
6. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	25. Prostate or male disorder	<input type="checkbox"/>	<input type="checkbox"/>
7. Back trouble	<input type="checkbox"/>	<input type="checkbox"/>	26. Rectal disorder (Piles)	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer or tumor	<input type="checkbox"/>	<input type="checkbox"/>	27. Sciatica	<input type="checkbox"/>	<input type="checkbox"/>
9. Confusion	<input type="checkbox"/>	<input type="checkbox"/>	28. Skin condition or disease	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	29. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
11. Dizziness or headaches	<input type="checkbox"/>	<input type="checkbox"/>	30. Stomach disorders	<input type="checkbox"/>	<input type="checkbox"/>
12. Epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	31. Thyroid or glandular	<input type="checkbox"/>	<input type="checkbox"/>
13. Eye, ear, nose or throat disorders	<input type="checkbox"/>	<input type="checkbox"/>	32. Ulcer (stomach or duodenal)	<input type="checkbox"/>	<input type="checkbox"/>
14. Gall bladder	<input type="checkbox"/>	<input type="checkbox"/>	33. Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>
15. Heart or circulatory	<input type="checkbox"/>	<input type="checkbox"/>	34. Any other condition or disease	<input type="checkbox"/>	<input type="checkbox"/>
16. High or low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	35. _____		
17. Intestines, bowel, or colon	<input type="checkbox"/>	<input type="checkbox"/>	36. _____		
18. Knee or other joint problems	<input type="checkbox"/>	<input type="checkbox"/>	37. _____		
19. Kidney or bladder	<input type="checkbox"/>	<input type="checkbox"/>	38. _____		

**If you have checked yes on any item(s) above, please explain on the next page
(use an extra sheet of paper if necessary)**

Please explain below the items that you checked “yes” on the previous page.

#	Year	Duration	Name and Nature of Injury, Disease, or Condition	Was Recovery Complete?	Name and Address of Physician

III. Have you been advised to have an operation that was not performed? Yes No
If yes, please give full details, including name and address of physician _____

IV. Have you been hospitalized in the last 5 years? Yes No
If yes, please explain below (use an extra sheet of paper if necessary). _____

Date of Hospitalization	Disease, Injury, or Condition	Name of Operation Performed if any	Name and Address of Physician

V. Are you planning to be hospitalized within the next 6 months? Yes No
If yes, please explain _____

VI. Have you taken any medication or drugs within the past 12 months? Yes No
If yes, please explain below (use an extra sheet of paper if necessary).

Medication	Prescribing Physician	Condition Requiring Medication	Still Taking?

ACKNOWLEDGEMENT

I acknowledge and understand that my health plan may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health-care treatment, payment or for the purpose of business operations necessary to administer health-care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at www.id.regence.com or by calling 1-800-632-2022.

Health information requested or disclosed may be related to treatment or services performed by:

- A physician, dentist, pharmacist or other physical or behavioral health-care practitioner;
- A clinic, hospital, long-term care or other medical facility;
- Any other institution providing care, treatment, consultation, pharmaceuticals or supplies or;
- An insurance carrier or group health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

This acknowledgement does not apply to obtaining information regarding psychotherapy notes. A separate authorization will be used for psychotherapy notes.

I understand and agree that upon acceptance of this application by Regence BlueShield of Idaho and payment of premium directly to Regence BlueShield of Idaho in advance, I am entitled to the benefits of the Medicare supplement policy, subject to its terms, limitations, and conditions, including any special endorsements and/or riders attached thereto.

I understand the purpose of this Statement of Health is to provide Regence BlueShield of Idaho with data for determining the qualification of myself for Regence BlueShield of Idaho coverage and I agree that this application shall become a part of the policy between Regence BlueShield of Idaho and myself.

I certify that all statements contained hereon are true to the best of my knowledge, and that all material information relating to my health is fully disclosed hereon. I agree that the falsity or omission of any information required hereon shall bar the right to service under policy if such answer is made with intention to deceive, or materially affects either the acceptance of this application or the hazard assumed by Regence BlueShield of Idaho.

Applicant Signature* _____ Date _____

*If signature by a personal representative of the subscriber/enrollee, please complete the following:

Personal Representative's Name:

Relationship to Individual: Parent Legal Guardian† Holder of Power of Attorney†

†Attach legal documentation of legal guardian or Holder of Power of Attorney.

Complete this section only if you are transferring from a Regence BlueShield of Idaho individual plan. I request cancellation of Regence BlueShield of Idaho individual plan coverage.

By authorized signature below, the applicant agrees to the following:

I understand that the benefits provided by Medicare and a Medicare Supplement plan may duplicate those benefits covered under my current Regence BlueShield of Idaho individual health plan. If accepted for a Medicare Supplement plan, I authorize Regence BlueShield to cancel my current Regence BlueShield of Idaho individual health plan coverage when my Medicare Supplement coverage begins.

APPLICANT SIGNATURE: _____ **DATE** _____

HOW DID YOU HEAR ABOUT REGENCE BLUESHIELD OF IDAHO?

Please check the box that best describes how you heard about Regence BlueShield of Idaho.

- Regence Group Plan Regence Individual Plan Web site Seminar Agent
 Radio Television Newspaper Direct mail Word of mouth
 Other: _____

AGENT INFORMATION

If application is being made through an agent, he or she must complete the following and the notice of replacement included with this application, if appropriate. If all information is not completed, the application will be returned.

1. List any other medical or health insurance policies sold to the applicant: _____

2. List policies that are still in force: _____

3. List policies sold in the past five years that are no longer in force: _____

Agent Name	Agent Number
I certify, to the best of my knowledge, that the applicant has truthfully completed the application and all health problems are listed. I further certify that I have verified that the person applying for coverage is eligible for Parts A and B of Medicare.	
_____ Agent/Signature	_____ Date