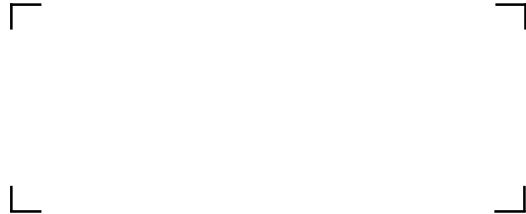




Regence

Regence BlueCross BlueShield of Oregon is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueCross BlueShield of Oregon



<h2>Washington Companion Plans Medicare Supplements Application</h2>	
<p>Plan A Plan C Plan F</p>	

Instructions for completing your application

Thank you for selecting Regence BlueCross BlueShield of Oregon (Regence BCBSO) for your Medicare Supplement Coverage. **You must be age 65 or older and have both Medicare Part A and Part B to apply for these plans.**

To assure prompt processing of your application, please be sure to:

1. Answer each required question completely **using ink**.
2. Enclose a photocopy of your Medicare Identification Card, or copy the information from your Medicare Identification Card into Section 1 of this application.
3. Sign and date the statements in Section 7 of this application.
4. If you are replacing current Medicare supplement coverage, please complete the enclosed "Notice to Applicant Regarding Replacement of Medicare Supplement Coverage" form.
5. If you need assistance completing this application, please call Customer Service at 1 (800) 365-3155 or contact your agent.

Section 1 - Enrollment Information

Social Security Number	Sex	Date of Birth	Height	Weight
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WASHINGTON RESIDENCE ADDRESS				
Last Name	First Name	Middle Initial		
Residence Street Address		PO Box (if applicable)		
City, State, ZIP Code				
Home Phone Number	Work Phone Number	County	OFFICE USE CO CODE	

BILLING ADDRESS (complete only if billing should be sent to an address other than listed above)	
Name c/o	Relationship to Applicant
Address	City, State, ZIP Code

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

EXAMPLE

MEDICARE HEALTH INSURANCE	
1-800-MEDICARE (1-800-633-4227)	
NAME OF BENEFICIARY SAMPLE A. SAMPLE	
MEDICARE CLAIM NUMBER 000-00-0000-A	SEX FEMALE
IS ENTITLED TO HOSPITAL (PART A) MEDICAL (PART B)	EFFECTIVE DATE 07-01-1986 07-01-1986

YOUR INFORMATION HERE

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

Check the Companion Plan you are applying for: (select **one** option)

Plan A Plan C Plan F

Effective dates are assigned on the first of the month following the date the application is approved. If a different effective date in the future is desired, please indicate the date in the area below.

Please Note: Companion Plan effective dates cannot be prior to your Medicare Parts A and B coverage start dates.

Requested Effective (Start) Date: 1st _____
(indicate month)

Section 2 - Proof of Residency

To be eligible for coverage, you must be a permanent resident of Clark County, in the State of Washington. In order to process your application, we need proof of your place of residency. Please include a photocopy of one of the following with your application: 1) Washington State driver's license, 2) Washington State ID Card, 3) Voter registration card, or 4) current utility bill.

Please Note: The address on your Proof of Residency must match your address listed on the application.

FOR OFFICE USE ONLY							
O.E.D. MO. DA. YR.	Group No.	Agreement No.	Current Effective Date	Current Months Column 22	P.E.	County	Broker #

Section 3 - Special Notice

- You do not need more than one Medicare supplement contract.
- If you purchase this contract, 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 contract.
- If, after purchasing this contract, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement contract 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 contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract 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 contract 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 contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement contract (or, if that is no longer available, a substantially equivalent contract) will be reinstated, if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract 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 specified low-income Medicare beneficiary (SLMB).

Section 4 - Other Insurance 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.

- A. Are you currently enrolled in a Regence BCBSO Individual medical plan? Yes No
 1. If yes, do you wish to terminate that coverage?..... Yes No

If you answered yes to both of the above questions, please sign the statement below:

I, _____ wish to terminate my individual medical coverage from Regence BCBSO effective _____ the effective date of this Medicare supplement contract.

Signature _____ Date _____

- B. Are you currently enrolled in MedAdvantage?..... Yes No
 1. If yes, do you wish to terminate that coverage?..... Yes No

If you answered yes to both of the above questions, please sign the statement below:

I, _____ wish to terminate my coverage from MedAdvantage effective _____ the effective date of this Medicare supplement contract.

Signature _____ Date _____

- C. 1. Did you turn age 65 in the last six months?..... Yes No
 2. Did you enroll in Medicare Part B in the last six months?..... Yes No
 3. If yes, what is the effective date?..... Yes No

- D. Are you covered for medical assistance through the 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:

1. Will Medicaid pay your premiums for this Medicare supplement contract?..... Yes No
 2. Do you receive any benefits from Medicaid **other than** payments towards your Medicare Part B premium?..... Yes No

- E. If you had 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), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.

Start _____ **End** _____

1. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?..... Yes No
 2. Was this your first time in this type of Medicare plan?..... Yes No
 3. Did you drop a Medicare supplement contract to enroll in the Medicare plan?..... Yes No

- F. 1. Do you have another Medicare supplement contract in force?..... Yes No
 2. If so, with what company, and what plan do you have?..... Yes No
 3. If so, do you intend to replace your current Medicare supplement contract with this contract?..... Yes No

- G. Have you had coverage under any other health insurance within the past 63 days?..... Yes No
 (For example, an employer, union, or individual plan.)
 1. If so, with what company and what kind of contract?.....

2. What are your dates of coverage under the other contract?

Start _____ **End** _____ (If you are still covered under the other contract, leave "End" blank.)

If you have had prior health coverage and are applying within 63 days of that coverage termination, you may be eligible for prior coverage credit for any limitations of coverage on these plans. [Note: In order to receive prior coverage credit, please attach a copy of your Certificate of Coverage (or forward when available) and the front and back of your prior plan ID card.]

Section 5 - Health Statement Requirements

Completion of the following health statement is not required for every applicant. Please read the following information carefully and **DO NOT** complete the health statement if any of the situations apply to you:

- ◆ If applying before the end of the first six months you are age 65 or older and have Medicare Part B. You must also have Medicare Part A to apply.
- ◆ If transferring from another Medicare supplement or Medicare Advantage plan; a health statement is **NOT** required for any of the transfers listed below:

<i>Transferring from a:</i>	<i>Transferring to:</i>
Plan A	Regence Companion Plan A
Plans B, C, D, E, F, G, K, L, or other more comprehensive plan	Regence Companion Plan A Regence Companion Plan C Regence Companion Plan F
Medicare Advantage plan	You may not be eligible for all plans. Please contact us for details.

PLEASE COMPLETE THE HEALTH STATEMENT IF NONE OF THE ABOVE SITUATIONS APPLY.

HEALTH STATEMENT

Washington State law requires that the health statement be completed by the applicant or the applicant's relative, legal guardian, or physician.

Please indicate whether or not you have received treatment for any of the following conditions within the last **five** years. Each condition must be checked yes or no.

CONDITION	YES	NO	CONDITION	YES	NO
1. AIDS or HIV positive.....	<input type="checkbox"/>	<input type="checkbox"/>	12. Vein or artery disease.....	<input type="checkbox"/>	<input type="checkbox"/>
2. Arthritis.....	<input type="checkbox"/>	<input type="checkbox"/>	13. Heart disease.....	<input type="checkbox"/>	<input type="checkbox"/>
3. Alcoholism.....	<input type="checkbox"/>	<input type="checkbox"/>	14. High blood pressure.....	<input type="checkbox"/>	<input type="checkbox"/>
4. Alzheimer's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>	15. Intestinal problems.....	<input type="checkbox"/>	<input type="checkbox"/>
5. Back trouble	<input type="checkbox"/>	<input type="checkbox"/>	16. Kidney/bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>
6. Cancer, Leukemia.....	<input type="checkbox"/>	<input type="checkbox"/>	17. Liver problems.....	<input type="checkbox"/>	<input type="checkbox"/>
7. Cataracts.....	<input type="checkbox"/>	<input type="checkbox"/>	18. Parkinson's Disease.....	<input type="checkbox"/>	<input type="checkbox"/>
8. Diabetes.....	<input type="checkbox"/>	<input type="checkbox"/>	19. Prostate disorders.....	<input type="checkbox"/>	<input type="checkbox"/>
9. Emphysema/lung disorders.....	<input type="checkbox"/>	<input type="checkbox"/>	20. Psychiatric care.....	<input type="checkbox"/>	<input type="checkbox"/>
10. Gall bladder problems.....	<input type="checkbox"/>	<input type="checkbox"/>	21. Stroke.....	<input type="checkbox"/>	<input type="checkbox"/>
11. Glaucoma.....	<input type="checkbox"/>	<input type="checkbox"/>	22. Have you been hospitalized or had surgery in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>

AUTHORIZATION SIGNATURE REQUIRED ON PAGE 7.

Section 6 - Premium Billing Options (if application is approved)

PLEASE DO NOT SEND MONEY WITH THIS APPLICATION.

Please indicate one billing option:

- Monthly (checking account deductions - see below)
- Quarterly Bill (every three months)
- Monthly Bill

SUREPAY AUTHORIZATION

Surepay is a simple and convenient way to keep your health coverage in force. If you select the Surepay option of paying for your Regence BCBSO health insurance the payment will be deducted automatically from your account on the 3rd business day of the month. This will provide several advantages to you:

- ◆ Your payment will always be made on time (if funds are available in your account).
- ◆ You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- ◆ Your monthly bank statement will show a withdrawal notation which is your receipt of payment.
- ◆ Please pay your paper bill until you are notified that your electronic funds transfer has been started. Processing may take up to 60 days.

GETTING STARTED is as easy as 1 - 2 - 3:

1. **Complete**, date and sign the authorization below.
2. **Write** "void" on one of your checks.
3. **Return** this completed form and your "voided" check (not a deposit slip).

SOME SUGGESTIONS:

- ◆ **Check register reminder:** When you receive your monthly statement be sure to enter the payment amount in your check register. This will help you keep your account in balance and avoid overdraft problems.
- ◆ **If you change your bank or wish to cancel your automatic deduction.**
 1. Do this at least 15 days before your next premium is due. We suggest you leave enough money in your old bank account to cover your payments in case there is a delay in processing the change.
 2. Just send us a copy of your new "voided" check and a note explaining that you have changed banks.
 3. Changes may also be made by calling Customer Service at 1 (800) 365-3155.

SUREPAY AUTHORIZATION

- 1. COMPLETE** and sign this authorization form. **2. ATTACH** your voided check (**not** a deposit slip).
3. RETURN to Regence BlueCross BlueShield of Oregon (PO Box 1271, MS5K, Portland, OR 97201-1271).

AUTHORIZATION TO MY BANK

Checking Account Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueCross BlueShield of Oregon, Portland, Oregon. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

 Account Holder's Name (please print)

▶ _____
 Account Holder's Authorized Signature(s) - as it appears on bank records

 Date

Section 7 - Applicant's Statements, Authorization, and Signature

TO ALL APPLICANTS: Your signature below applies to the following statements and authorization:

RECEIPT OF PLAN INFORMATION AND EFFECTIVE DATE: I am enrolled in Medicare A and B. I understand that by signing this application, I am applying for Regence BlueCross BlueShield of Oregon (Regence BCBSO) Medicare supplement coverage. My signature below also acknowledges that I have received the Regence BCBSO COMPANION PLAN packet, the brochure "Guide to Health Insurance for People with Medicare" and the "Outline of Coverage" about the COMPANION PLANS.

I understand that if my application is approved, my contract will become effective on the first of the month following the date Regence BCBSO receives the completed application for processing.

I further understand that the COMPANION PLANS each include a three-month waiting period for pre-existing conditions. (This waiting period may be reduced by the amount of your prior creditable coverage if the most recent period of creditable coverage ended within 63 days of your effective date of coverage under this contract.)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I authorize any physician, health-care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to Regence BCBSO or its representatives my health information (including alcohol, chemical dependency, mental treatment, genetic testing or HIV treatment). I acknowledge and understand that this information will only be used for the purpose of determining eligibility for benefits. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

I may cancel this authorization at any time by sending a written request to Regence BCBSO. My cancellation of this authorization will not affect any action Regence BCBSO took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with Regence BCBSO or 24 months from the date below, whichever comes first.

Federal law requires Regence BCBSO to tell me that, if the party to whom Regence BCBSO discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, Part 2). Federal law prohibits redisclosure of alcohol and drug abuse records without specified written authorization.

If you choose not to sign this authorization, we may be unable to enroll you in our health plan or to pay claims that were incurred while you had insurance coverage with us.

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence BCBSO to enroll in their coverage. I understand that Regence BCBSO will rely on each answer in making coverage and rating determinations. For the protection of all of the Regence BCBSO members, knowingly providing Regence BCBSO with false, incomplete or misleading information may result in Regence BCBSO taking any action allowed by law or contract, including termination or rescission of coverage, denial of benefits, and/or pursuit of criminal charges and penalties. If coverage is rescinded for fraud or intentionally misleading statements, Regence BCBSO will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence BCBSO in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence BCBSO. I also understand that if this application is accepted by Regence BCBSO, it will become part of the COMPANION PLAN contract. Regence BCBSO may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

I understand that my agent is not authorized to make any statements about the benefits, conditions or limitations of the contract except through written materials furnished by Regence BCBSO. If my agent has completed any answers for me, I have reread all answers, and verified that they are true and complete. I understand that only Regence BCBSO can determine whether to issue a contract to me, and that my agent has no authority to do so.

X _____ DATE _____
APPLICANT SIGNATURE * _____

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

Personal Representative's Name (please print) _____

Relationship to Individual _____ (Attach legal documentation)

Legal Guardian Holder of Power of Attorney (Attach legal documentation if Legal Guardian or holder of Power of Attorney)

Section 8 - Agent Information

FOR AGENT USE ONLY

I (the Agent) have explained the eligibility provisions to the Applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence BCBSO. The Applicant has been informed that the effective date of coverage is assigned only by Regence BCBSO.

I certify that the information supplied to me by the applicant has been truly and accurately recorded here.

Agents must list any other medical or health contracts sold to the applicant.

List contracts sold which are still in force _____

List such contracts sold in the past five years which are no longer in force _____

Agent Name	Agent E-mail	Agent Number	
Agency Name	Telephone Number	Fax Number	
Street Address	City	State	Zip Code
Agent's Signature		Date	

Do not send payment with your application. We will bill you upon acceptance of your application.

**Please return this application to:
Regence BlueCross BlueShield of Oregon
Attn: Individual Enrollment Services, Mail Station E-8U
P.O. Box 1271
Portland, OR 97207-1271
(503) 220-6363
1 (800) 365-3155**

FOR OFFICE USE ONLY

Additional telephone information received by Regence BlueCross BlueShield of Oregon

Washington Companion Plans Application Checklist

Thank you for completing, signing, and dating this Washington Companion Plans Application. We've provided a checklist below to help ensure that your application is complete, and to avoid any unnecessary delay in processing.

- I have used ink when completing this application. An application completed in pencil will be returned to me.
- I have provided all requested information in Section 1.
- I have included a copy of my Medicare Identification Card, or copied the information from my Medicare Identification Card into Section 1.
- I have included Proof of Residency in Clark County. Valid proof includes a copy of: 1) a Washington driver's license, 2) a voter registration card, or 3) a recent utility bill. The address on my Proof of Residency is the same as my residence address listed on my application.
- I have read the statements in Section 3.
- I have answered ALL questions in Section 4.
- I have completed the health statement in Section 5 (if applicable.)
- I have chosen a billing option in Section 6. If I chose monthly automatic checking account deductions, I have attached a voided check. (Note: If selecting monthly automatic checking account deductions, upon acceptance, please pay your paper bill until you are notified that your electronic funds transfer has been initiated. Processing may take up to 60 days.)
- I have not attached my premium payment with this application. I understand that Regence BCBSO will bill me upon acceptance.
- I have read, signed, and dated the Applicant's Statements and Authorization in Section 7.
- If an agent helped me complete these forms, he or she must complete the Agent Information in Section 8.