

# APPLICATION FOR SUPPLEMENT TO MEDICARE

**You must have both Medicare Part A and Part B to apply for these plans.**



## Regence

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

1800 Ninth Avenue  
P.O. Box 91053  
Seattle, Washington 98111-9153  
206 464-3804 • 1 888 344-8234

**MAIL APPLICATION TO:**  
PO Box 1107  
1602 21<sup>st</sup> Ave. MS LC1NW  
Lewiston, ID 83501

**PLEASE READ THE FOLLOWING INFORMATION BEFORE COMPLETING THIS FORM.**

- 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.
- If you are 65 or older, 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 rates under your Medicare supplement contract 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 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 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 rates under your Medicare supplement contract can be suspended, if requested, while you are covered under the employer or union-based group health benefit 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 a "Specified Low-Income Medicare Beneficiary" (SLMB).

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

**Section 1. APPLICANT INFORMATION**

Name			Birth Date	Age	Social Security Number	
First	MI	Last				
Street Address			CITY		STATE	ZIP CODE
Mailing Address			CITY		STATE	ZIP CODE
Billing Address (if different)			CITY		STATE	ZIP CODE
Telephone		<input type="checkbox"/> Male <input type="checkbox"/> Female		Email Address		

**Section 2. COVERAGE APPLIED FOR:**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> <b>A – Base Plan</b>    | <input type="checkbox"/> <b>E - Alpine Plan</b> | <input type="checkbox"/> <b>J - Discover Plan</b> |
| <input type="checkbox"/> <b>C - Cascade Plan</b> | <input type="checkbox"/> <b>F - Vista Plan</b>  |   |

_____	_____	_____
Effective Date	Package #	Agent #

### Section 3. MEDICARE HEALTH INSURANCE CARD

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) _____	

### Section 4. TYPE OF BILLING DESIRED

- Automatic Bank Withdrawal (*Complete the Subscriber Agreement for Preauthorized Bill Payment form.*)
- Standard Billing/Payment by Check (*Indicate desired billing schedule below.*)
- Monthly       Quarterly       Semiannually       Annually

### Section 5. TYPE OF APPLICATION

- New
- Transferring from another Blue Shield plan.
- Name of Plan \_\_\_\_\_
- Converting from a Regence BlueShield group plan.
- Converting from another company.
- Name of Company \_\_\_\_\_
- Name/type of Policy \_\_\_\_\_
- Converting from a Regence BlueShield individual plan.

---

### Section 6. INDIVIDUAL PLAN CANCELLATION ACKNOWLEDGEMENT

**Complete this section only if you are transferring from a Regence BlueShield individual plan.**

**I request cancellation of Regence BlueShield 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 individual health plan. If accepted for a Medicare Supplement plan, I authorize Regence BlueShield to cancel my current Regence BlueShield individual health plan coverage when my Medicare Supplement coverage begins.

**APPLICANT SIGNATURE:** \_\_\_\_\_ **DATE** \_\_\_\_\_

---

**Section 7. OTHER COVERAGE 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 TO THE BEST OF YOUR KNOWLEDGE**

**(please mark Yes or No with an "X").**

Yes No

(A) Did you turn 65 in the last 6 months?  Yes  No

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

**If Yes:** What is the effective date? \_\_\_\_\_

(C) 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:** Will Medicaid pay your rates for this Medicare supplement contract?  Yes  No

**If Yes:** Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  Yes  No

(D) 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     /     /                      \_\_\_\_\_

(E) 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

(F) Was this your first time in this type of Medicare plan?  Yes  No

(G) Did you drop a Medicare Supplement policy to enroll in the Medicare plan?  Yes  No

(H) Do you have another Medicare supplement policy in force?  Yes  No

**If Yes:** With which company and what plan do you have?  
\_\_\_\_\_

**If Yes:** Do you intend to replace your current Medicare supplement policy with this contract? **Please complete the enclosed "Notice to Applicant Regarding Replacement of Medicare Supplement Coverage" form.**  Yes  No

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

**If Yes:** With which company? \_\_\_\_\_

**If Yes:** What kind of policy? \_\_\_\_\_

**If Yes:** What are your dates of coverage under the other policy? If you are still covered under this plan, leave "END" blank.

START     /     /                      END     /     /                      \_\_\_\_\_





**Section 9. 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 BlueShield ("Regence") or its representatives my health information (including alcohol, chemical dependency, mental health treatment, genetic testing, or HIV treatment). I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan, eligibility for benefits, or payment of claims. 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 understand that any charge for obtaining the information will be my responsibility.

If I choose to not sign this authorization, Regence may be unable to enroll me in the health plan or to pay claims that were incurred while I had insurance coverage with Regence.

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

Federal Law requires Regence to tell me that if the party to whom Regence 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 this information without specific written authorization. **Please sign and date on Page 7.**

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES.  
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversations during a counseling session.)

**AUTHORIZATION SIGNATURE**

I understand that a true copy of this application will be attached to my contract when it is issued.

I have provided these answers as part of the application procedure required by Regence BlueShield to enroll in coverage and I certify that all information completed on this form is true, correct, and complete. I understand that Regence BlueShield will rely on each answer in making coverage and rating determinations. For the protection of all of our members, fraud or misrepresentation of material fact by me for the purposes of defrauding Regence BlueShield may result in Regence BlueShield 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.

I hereby authorize the Centers for Medicare and Medicaid Services (Medicare) to release to Regence BlueShield any information from Title XVIII (Medicare) that is required to process my claims in conjunction with Medicare, if applicable; additionally, Regence BlueShield may release such information about me to properly coordinate benefits with processors of Medicare claims. This authorization is ongoing for as long as I am or will be eligible for Medicare and remain enrolled in this plan.

I acknowledge that I have received a copy of the following (check all that apply):

- Choosing a Medigap Policy
- Notice of Replacement Coverage
- Outline of Coverage

**Please sign and date on next page.**

**Section 10. AGENT INFORMATION**

If you have an agent, that agent may receive commissions from Regence BlueShield. Commissions are paid at the same flat rate for the life of the consumer, as long as the policy remains in effect. These commissions may have an indirect impact on your rates. For more information, please contact your agent.

**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
<p>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.</p>	
_____ Agent/Signature	_____ Date

**Section 11. APPLICANT SIGNATURE**

**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<sup>†</sup>  Holder of Power of Attorney<sup>†</sup>

<sup>†</sup>**Attach legal documentation if Legal Guardian or Holder of Power of Attorney.**

Requested Effective Date: \_\_\_\_\_

**HOW DID YOU HEAR ABOUT REGENCE BLUESHIELD?**

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

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