South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

BLUECARE® APPLICATION
(Medicare Supplement)

www.SouthCarolinaBlues.com
P.O. Box 100186 • Columbia, SC 29202-3186

Part I. GENERAL INFORMATION

For Office Use Only
ID#
Keycode

1. Print Name: _____
(Title) (First) (Middle) (Last)

2. Residence Address: _____
(No. and Street and Apt. No.) (City) (State) (ZIP Code)

3. Mailing Address: _____
(No. and Street and Apt. No.) (City) (State) (ZIP Code)

Birth Date: ____/____/____ Age: _____ ☐ Male ☐ Female
Mo. Day Yr. (*Current Age*)

Social Security Number: _____

Home Phone No.: (____) _____
(Area Code)

E-mail Address: _____

Did you turn age 65 in the last six months? ☐ Yes ☐ No Have you signed up for Medicare Part B? ☐ Yes ☐ No

If you answered "yes" to this question, you do not need to complete the Health/Medical Questions, and the pre-existing condition limitation will not apply to you.

Have you used any form of Tobacco products in the past 12 months? ☐ Yes ☐ No
(i.e. cigarettes, cigars, pipes, snuff or chewing tobacco)

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible to qualify for a guaranteed issue 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.

Household Discount (If Application is Approved and Eligibility requirements are met)

You may receive a premium discount if you qualify. Eligibility for the Household discount requires two or more members to reside at the same physical address and enrolled in a BlueCross BlueShield of SC plan purchased after June 2010 or Blue Choice. If you meet these eligibility rules, please include the pertinent information for you and the person with which you are qualifying, or applying with:

Name of other eligible Member _____

Member ID or Medicare number of the other eligible Member _____

Which Plan Are You Applying For?

Please fill in the Plan for which you are applying. _____

Please Provide Your Medicare Insurance Information

Please take out your Medicare card to complete this section.

- Please fill in these blanks so they match your red, white and blue Medicare card.
  – OR –
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have attained 65 years of age, have Medicare Part A and Part B to purchase a Medicare Supplement policy and to have the policy become effective.

Medicare | Health Insurance

SAMPLE ONLY

Name: _____

Medicare Beneficiary Number: _____ Sex: _____

Is Entitled To: Effective Date:

HOSPITAL (Part A) _____
MEDICAL (Part B) _____

Billing Information

How do you wish to be billed? ☐ Monthly Bank Draft* ☐ Monthly Billing ☐ Monthly Credit Card Billing

*If you choose Monthly Bank Draft or Credit Card, complete the authorization agreement on Page 4 and attach a voided check along with your first premium, if applicable. Please note: If the effective date is the 1st, the draft will be on or after the 3rd of each month. If the effective date is the 15th, the draft will be on or after the 15th of each month.

Requested Effective Date: ☐1st ☐15th **Please note: Current South Carolina BlueCross Medigap customers will be assigned an effective date that is consistent with their current coverage.**

PART II. HEALTH/MEDICAL QUESTIONS

Height:_____Ft._____In. Weight_____Lbs.

1. In the last five years, have you had medical or surgical advice, treatment or consultation for any of the following conditions:
   a. ☐ Yes ☐ No Heart attack, congestive heart failure, heart failure, enlarged heart or heart procedure or surgery (prior or not yet performed); aneurysm; peripheral vascular disease (poor circulation in your extremities); any stent placement; stroke or transient ischemic attack (TIA)?
   b. ☐ Yes ☐ No Emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, tuberculosis or other chronic lung disorder (excluding mild or moderate asthma)?
   c. ☐ Yes ☐ No Chronic kidney disease, kidney failure or kidney dialysis?
   d. ☐ Yes ☐ No Crippling or disabling arthritis or bone disease, osteoporosis with fracture(s) or hip replacement?
   e. ☐ Yes ☐ No Alzheimer's disease, dementia, organic brain disorder, any senility disorder, Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS) or Systemic Lupus?
   f. ☐ Yes ☐ No Internal cancer, malignant melanoma, leukemia, Hodgkin's disease, lymphoma or bone marrow or organ transplant (except cornea)?
   g. ☐ Yes ☐ No Diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), ever had any amputation due to diabetes or ever required more than 50 units of insulin daily?
   h. ☐ Yes ☐ No Alcohol or drug abuse or misuse, cirrhosis of the liver or other chronic liver disease?
   i. ☐ Yes ☐ No Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV)?
   j. ☐ Yes ☐ No Are you currently totally disabled, bedridden, hospitalized or confined to a nursing or other facility?
2. ☐ Yes ☐ No Do you need assistance, supervision or a wheelchair for any daily activities such as dressing, eating, bathing or walking?
3. In the last two years:
   a. ☐ Yes ☐ No Have you had medical advice, treatment or consultation for any psychological, psychiatric, mental or nervous disorders?
   b. ☐ Yes ☐ No Have you been advised or recommended to receive treatment for any condition that would require surgery, hospitalization, or confinement to a facility?
   c. ☐ Yes ☐ No Have you been advised by a physician to have medical tests, treatment or therapy that has not been performed?
   d. ☐ Yes ☐ No Have you taken or been prescribed three or more prescription medications on a regular basis?

If you answer "Yes" to the above questions, please provide details below:

Question #	Date of Onset/Recovery	Condition/Daily Activity Limitations	Treatment/Medication/Type of Assistance Needed	Doctor Name/Phone #

4. ☐ Yes ☐ No Are you a diabetic controlled by diet or oral medications?
5. ☐ Yes ☐ No In the last 12 months, have you taken or been prescribed any prescription medications? If "Yes," please provide details for all medications below.

Medication	Date Started/Stopped	Dosage/Frequency	Reason for Taking Medication

Please list additional medications on a separate sheet of paper and submit the list with this application.

PART III. EXISTING COVERAGE INFORMATION (complete in full)

1. a. Do you have another Medicare Supplement insurance policy in force? ☐ Yes ☐ No
   b. Have you had coverage under other health insurance other than Medicare Advantage within the past 63 days? (For example, an employer, union or individual plan.) ☐ Yes ☐ No
   c. If so, with what company and what plan do you have?

Name of Company	Policy/Certificate Number	Plan/Kind of Policy	Issue Date

   d. If so, do you intend to replace your current policy with this policy? ☐ Yes ☐ No
   e. If "Yes," indicate termination date: _____
   Mo. Day Yr.

   YOU MUST NOTIFY YOUR EXISTING INSURANCE COMPANY OF YOUR TERMINATION DATE.

2. a. Have you had coverage from any Medicare plan other than the original Medicare within the past 63 days? (For example, a Medicare Advantage plan or a Medicare HMO or PPO.) ☐ Yes ☐ No
   Fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.
   Start: ____/____/____ End: ____/____/____
   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. Reason for termination/disenrollment: _____
   d. Planned date of termination/disenrollment: ____/____/____
   e. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   f. Did you drop a Medicare Supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No

   YOU MUST NOTIFY YOUR EXISTING INSURANCE COMPANY OF YOUR TERMINATION DATE.

3. Are you covered for medical assistance through the Medicaid program? 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. ☐ Yes ☐ No

   If "Yes,"
   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   b. Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? ☐ Yes ☐ No

IMPORTANT NOTE: If you have a minimum of six months creditable coverage, the pre-existing conditions exclusions will not apply to you.

Agent Use Only

a. List policies sold which are still in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

b. List policies sold in the past five years which are no longer in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

Consumer Protection Information

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- 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 policy (or, if that policy is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If your 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 suspension.
- 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 reinstituted 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 reinstituted policy 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 Read and Sign this Portion of the Enrollment Form

Read carefully before signing: To determine my insurability or for claims purposes, I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, institution or person that has any past and future medical records or knowledge of my health to give to Blue Cross and Blue Shield of South Carolina, or any of its reinsurers, any such information. I understand and agree that this authorization will remain valid: (a) for the purpose of collecting information to determine my insurability for 24 months from the date I sign this application and (b) for the purpose of collecting information in connection with a claim for benefits for the period of time I am covered under the policy. I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of an Outline of Coverage and the Medicare Supplement Buyer's Guide from the agent whose signature is below.

I agree that the information given by me on this application is complete, true and correctly recorded and this application will become a part of my contract. My coverage will not become effective until Blue Cross and Blue Shield of South Carolina accepts this application and until the premium plus any policy fee is paid. Approval may be based on my insurability as stated in my application. Coverage will become effective on the 1st or the 15th of the month.

I understand that I must be a South Carolina resident, have both Medicare Parts A and B and be at least age 65.

I will have a six-month pre-existing limitation period from the effective date of the policy before I can receive benefits for any pre-existing conditions for which I have received medical advice or treatment during the six-month period immediately prior to my policy effective date.

Applicant's Signature: _____ Date: _____

Agent's Signature: _____ Code: _____ Date: _____

Authorization Agreement For Bank Draft/Credit Card Payments

If you choose Monthly Bank Draft or Credit Card, complete the authorization agreement below and attach a voided check, if applicable.

☐ **Bank Draft** Bank Name:_____ Bank Routing Number:_____

City:_____ State:_____ ZIP:_____

My Account No.:_____ Name on Account:_____

☐ **Credit Card** ☐ Visa ☐ Master Card ☐ Discover Expiration Date:_____

My Account No.:_____ Name on Account:_____

Corporation Name: Blue Cross and Blue Shield of South Carolina

I authorize Blue Cross and Blue Shield of South Carolina to initiate debit/charge entries to my checking account/credit card below and the Bank/Corporation named to debit/charge my account.

This authority is to remain in force until the Bank/Corporation has received written notification from me of its termination in such time and such manner as to afford the Bank/Corporation a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the Bank/Corporation prior to charging the account. If Blue Cross and Blue Shield of South Carolina initiates an erroneous debit entry to a customer's account, the customer shall have the right to have the amount of the entry credited to his/her account by the Bank/Corporation. If, within 15 calendar days following the date on which the Bank/Corporation sent to the customer a statement of account or written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank/Corporation a written notice identifying the entry, stating that the entry was in error and requesting the Bank/Corporation to credit the amount to his/her account.

Your Name:_____ I.D.#_____

Signed: _____ Date:_____

For Use of Blue Cross and Blue Shield of South Carolina

Effective Date			End Date			Cancel	Process	I.D. Code	Accept	Reject	Underwriting