BlueCross BlueShield of Kansas City

Medicare Supplement Application

☐ Check if eligible for Medicare due to a disability **REQUESTED EFFECTIVE DATE:**

I – Coverage Selection	**Method of Payment** ☐ **Annual** ☐ **Semi-Annual** ☐ **Quarterly** ☐ **Monthly**	**FOR OFFICE USE ONLY**

PLEASE INDICATE THE MEDICAL PLAN YOU ARE APPLYING FOR

Medicare Supplement	**Medicare Select (Selected Hospitals – Unrestricted Physicians)}**	**DENTAL COVERAGE**
☐ A ☐ F ☐ C ☐ J	☐ A – Select ☐ C – Select ☐ F – Select ☐ J - Select **Please read and sign attached disclosure**	☐ I wish to enroll in the individual dental plan for Type I and Type II services

If I do not meet the health requirements for the plan I chose above, please automatically enroll me at the guaranteed rate in (Check ONE): ☐ Plan A or ☐ Plan C

Please accept my signature as authorization for this request: _____

FOR OFFICE USE ONLY

Date Received

Group: **10001000**

Subgroup

Class

Health Plan

Area/Issue Age

Effective Date

Pre-X Effective Date

Premium

Reason for Risk

Closed Date

II – Applicant Information

Name (Last Name, First Name, Middle Initial)

Home Address (Street Number and Name)

City, State, County and Zip Code

Social Security Number	Birth Date	Home Telephone Number (Including Area Code)

Note: Complete item 6 only if billing is to be sent to an address other than your home address.

Billing Address (Street Number and Name)

City, State, County and Zip Code

III – Other Information Required for Issuance & Continuous Coverage

Please complete the information as it appears on your Medicare card. Or, attach a copy of your Medicare card or your Letter of Verification from the Social Security or Railroad Retirement Office. We cannot consider this form "complete" until we have obtained this information.

PLEASE COMPLETE THE INFORMATION <u>IN THE BOX TO THE RIGHT</u> AS IT APPEARS ON YOUR MEDICARE CARD --->

MEDICARE **HEALTH INSURANCE**

SOCIAL SECURITY ACT

NAME OF BENEFICIARY

_____

MEDICARE CLAIM NUMBER SEX

_____ - _____ - _____ _____

IS ENTITLED TO EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) _____-_____-_____

MEDICAL INSURANCE (PART B) _____-_____-_____

(NOTE, IF YOUR SPOUSE WOULD LIKE TO APPLY, A SEPARATE APPLICATION MUST BE COMPLETED)

Last Name:	First Name:

III – Other Information Required for Issuance and Continuous Coverage (Continued)

CHECK "YES" OR "NO" FOR EACH QUESTION BELOW, (please answer all questions to the best of your knowledge)	**YES**	**NO**
1. A. Did you turn age 65 in the last 6 months?		
B. Did you enroll in Medicare Part B in the last 6 months?		
C. If yes, what is the effective date? Date: _____		
2. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-down Program" and have not met your "Share of the Cost," please answer NO to this question.)		
A. If yes, will Medicaid pay your premiums for this Medicare supplement policy?		
B. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?		
3. A. 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 / /		
B. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?		
C. Was this your first time in this type of Medicare Plan?		
D. Did you drop a Medicare supplement policy to enroll in the Medicare plan?		
4. A. Do you have another Medicare supplement policy in force?		
B. If so, with what company and what plan do you have? Company: _____ Plan: _____ When was your policy effective: _____ Co. Phone Number: _____		
C. If so, do you intend to replace your current Medicare supplement policy with this policy?		
5. A. Have you had coverage under any other health insurance within the past 63 days? (For example, employer,or individual)?		
B. If so, with what company and what kind of policy? Company: _____ Co. Phone Number: _____		
C. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank? Start / / End / /		

Last Name:	First Name:

IV – Required Notices

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 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 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. 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 reinstitued if requested within ninety (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 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). 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.

If you or your spouse have Blue Cross and Blue Shield coverage, please complete the following: **(NOTE, IF YOUR SPOUSE WOULD LIKE TO APPLY, A SEPARATE APPLICATION MUST BE COMPLETED.)**

Blue Cross and Blue Shield Plan location (City and State)	
Certificate/Identification Number	

IV – Medical Questionnaire: IF YOU ARE WITHIN 6 MONTHS OF BEING ELIGIBLE FOR MEDICARE PART B, YOU ARE NOT REQUIRED TO COMPLETE THE HEALTH QUESTIONS LISTED BELOW.

Height: _____	Weight: _____

YES	NO	IF ANY QUESTIONS ARE ANSWERED "YES", PLEASE EXPLAIN ON THE NEXT PAGE:
		1. Within the past three years have you had or been treated for a stroke, phlebitis, heart attack, chronic heart condition or congestive heart failure?
		2. Have you ever had heart valve surgery, a pacemaker or other implanted cardiac device?
		3. Within the past three years have you been diagnosed with or treated for any type of cancer, excluding common skin cancer?
		4. Within the past three years have you been diagnosed with or treated for Parkinson's Disease, Alzheimer's Disease, Dementia or Bipolar disorder?

Last Name:	First Name:

IV – Medical Questionnaire (continued)

		5. Have you ever been diagnosed or treated for emphysema, any chronic lung condition or use oxygen?
		6. Have you had an amputation due to disease or trauma?
		7. Any complications from diabetes including retinopathy, neuropathy, edema or kidney disease? Have you ever been advised to have dialysis of any kind?
		8. Any treatment for severe disabling arthritis, fibromyalgia, myasthenia gravis, lupus, multiple sclerosis, amyothrophic lateral sclerosis (ALS), paralysis, joint replacement or organ transplant of any kind?
		9. Ever been diagnosed or treated for drug or alcohol abuse, cirrhosis of the liver, HIV, AIDS or AIDS related complex (ACR)?
		10. Have you been advised to have surgery or treatment not yet performed?
		11. Do you walk with a cane or walker, use a wheelchair or are you bedridden?
		12. Have you been hospitalized, inpatient or outpatient within the last 2 years?
		13. Are you currently taking any medications?

Give complete details of each item checked "YES" from above (attach separate sheet if additional space is needed)

Question #	Type of Ailment or Diagnosis of Condition	Date of Condition	Date of Last Treatment	Date of Surgery	Prescription Drugs Being Taken	Name(s) and Address(es) of Physician(s)

V - Agreement

I understand and agree that any incorrect statements made by me in this application will invalidate my coverage and that all statements made by me will, in the absence of fraud, be deemed representations and not warranties. I realize that any fraudulent misrepresentation regarding the presence of preexisting impairments or disease will result in cancellation of my coverage retroactive to the effective date. This application is submitted subject to all the terms and conditions of the policy under which application is made. I hereby agree to accept all terms and conditions of the policy. I acknowledge that I have received an outline of coverage.

Applicant's Signature: _____ Date: _____

Last Name:	First Name:

VI – BCBS Broker/Agent information to be filled out by BCBS Broker/Agent ONLY. *(If Applicable)*

BCBS Broker/Agent Signature, if applicable	BCBS Broker/Agent Identification Number - (8 Characters)	BCBS Broker/Agent E-Mail Address
Printed Name: _____ Signature: _____		

To be completed ONLY by the broker/agent whose signature is shown above

1. List any health insurance policies you have sold to the applicant which are still in force:

2. List any other health insurance policies you have sold to the applicant in the past five (5) years which are no longer in force:

Would you like to eliminate the hassle of writing a check each month for your health care premium?

- With Tech-No-Check electronic funds transfer, your monthly premium is automatically deducted from your checking account.
- Your premium will be paid automatically, on time, each and every month.
- Your account will be drafted on the 5th of each month or next business day.
- You will be notified when Tech-No-Check is in force. (Pay as billed until you are notified that Tech-No-Check is activated).
- Just complete the section below, sign and attach a VOIDED check.

Yes, I want Tech-No-Check. Attached is a VOIDED check for my account

Name:	Social Security No.:
Signature:	Date:

CREDIT CARD AUTHORIZATION: We offer the convenience of paying by credit card. Payment by credit card can be accepted for a payment of one or more premiums; or with your signed authorization, we can automatically charge your credit card for your full premium each month. To pay by credit card, select one of the following options (*all information must be complete for processing)*:

☐ Please charge my credit card for one premium payment in the amount of $.

☐ Please charge my credit card automatically each month for the full premium amount due. I understand that my credit card will be charged each month on the _____ day of the month. Choose only one: ☐ Visa ☐ Master Card ☐ Discover ☐ American Express

Account Number: _____ Account Name: _____ Expiration Date: _____

Signature: _____

NOTE: To cancel your automatic credit card authorization, your request must be received 10 days prior to your credit card withdrawal date.

Medicare Select Disclosures

If you are applying for Medicare Select, please review this information and sign the back of this form. We must have this form completed to process your application.

- **Outline of Coverage – *See Enclosed Outline.***

- **Description of Preferred Network Providers.**

  The following facilities are open 24 hours a day, seven days a week:

  Baptist-Lutheran Medical Center, (816) 276-7000, 6601 Rockhill Rd., Kansas City, MO 64131
  Cass Medical Center, (816) 884-3291, 1800 E. Mechanic Street, Harrisonville, MO 64701
  Excelsior Springs Medical Center, (816)630-6081, 1700 Rainbow Blvd., Excelsior Springs, MO 64024
  Independence Regional Health Center, (816) 836-8100, 1509 W. Truman Rd., Independence, MO 64050
  Lafayette Regional Health Center, (660) 259-2203, 1500 State Street, Lexington, MO 64067
  Lee's Summit Hospital, (816) 969-6000, 530 NW Murray Rd., Lee's Summit, MO 64081
  Medical Center of Independence, (816) 373-2300, 17203 E. 23rd St., Independence, MO 64057
  Menorah Medical Center, (913) 345-3600, 5721 W. 119th St., Overland Park, KS 66209
  North Kansas City Hospital, (816) 691-2000, 2800 Clay Edwards Dr., North Kansas City, MO 64116
  Overland Park Regional Medical Center, (913) 541-5000, 10500 Quivira Rd., Overland Park, KS 66215
  Research Belton Hospital, (816) 348-1200, 17065 S. 71 Highway, Belton, MO 64012
  Research Medical Center, (816) 276-4000, 2316 E. Meyer Blvd., Kansas City, MO 64132
  University of Kansas Medical Center, (913) 588-5000, 3091 Rainbow Blvd., Kansas City, KS 66103

- **Description of Restricted Network Provisions**

  You must use a preferred hospital provider for the Medicare Select programs to receive the highest level of benefits. We will pay Part A supplemental benefits if you receive care at preferred hospitals. You must also receive services in a preferred hospital to receive the highest level of benefits for inpatient physician charges. We will cover the Part B supplemental benefits if you receive inpatient physician services in a preferred hospital. We will cover the Part B supplemental benefits for Medicare-covered services performed by any physician outside the hospital, if the plan you choose includes benefits for Part B services.

- **Description of coverage for emergency and urgently needed care and other out-of-service area coverage.**

  An emergency is an injury, illness or physical condition that requires immediate diagnosis and treatment for a condition that occurs suddenly and unexpectedly, and that could become a threat to life or limb if medical services are not rendered immediately.

  In an emergency, or if urgently needed care is necessary out of the area, you are not required to use a preferred hospital provider. In an emergency situation and when care is urgently needed, full plan benefits are paid when any provider is utilized.

- **Description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the insurer.**

  In the event the Secretary of Health and Human Services does not re-authorize the Medicare Select program, you will be provided continuation of coverage.

  1. You will have the opportunity to purchase any Medicare Supplement certificate offered by us which has comparable or lesser benefits and which does not contain a restricted network provision. Evidence of insurability is not required in t his instance.

  2. A Medicare supplement certificate is considered to have comparable or lesser benefits if the new certificate does not contain one or more significant benefits not included in the Medicare Select Contract being replaced. A significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

- **Description of the Medicare Select insurer's quality assurance program.**

  The Quality Improvement program includes on-going assessments of the structure, process and outcome of patient care. These assessments are aimed at problem identification and resolution. The Plan is coordinated by Blue Cross and Blue Shield of Kansas City quality improvement support staff and involves the medical director(s), the Quality Improvement Committee, Blue Cross and Blue Shield of Kansas City staff members, and physician and non-physician providers.

- **Description of the Medicare Select insurer's grievance procedure**

  - *Purpose of grievance and complaint procedures.* It is our hope that Medicare Select members will move through the health care system with ease. However, we know that some situations may arise which will not meet your expectations. If this occurs, you may wish to verbally express your position or your may wish to formally file a written complaint.

  - *Procedures for filing a grievance.* Grievances and complaints will be handled by the Grievance Coordinator who may involve other staff members or providers of care in making the determination. The objective is to handle the complaint as quickly and as courteously as possible. You may bring a grievance or complaint to our attention by telephone or letter. You may call us at (816) 395-2345 or write to: Blue Cross and Blue Shield of Kansas City, Attn: Medicare Select Grievance Coordinator, P.O. Box 419071, Kansas City, MO 64141-2428.

Acknowledgment: _____ Date: _____

I hereby acknowledge and certify that I have carefully and completely read the Medicare Select disclosures above and I understand all restrictions and other information described above regarding Blue Cross and Blue Shield of Kansas City's Medicare Select product.

PLEASE RETURN THIS ACKNOWLEDGMENT FORM WITH YOUR COMPLETED APPLICATION. WE MUST HAVE THIS FORM TO PROCESS YOUR APPLICATION IF YOU ARE APPLYING FOR MEDICARE SELECT.