BlueCross BlueShield TX Packet (GI)

Thank you for your interest in applying for the BlueCross BlueShield of Texas Medicare Supplement plan!

You have access to a copy of the policy Enrollment Form (downloadable .pdf) as well as a printable copy of the Outline of Coverage and also a link to their online application.

Should you decide to apply by upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to BlueCross BlueShield of Texas. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: client.services@cda-insurance.com
- Secure File Upload: Click here
- Mail: CDA Insurance LLC
  PO Box 26540
  Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf) **Online application** Download Policy Outline (.pdf) Download Application (.pdf)

Our website: http://www.medicare-texas.net

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

BlueCross BlueShield of Texas

Application for Medicare Supplement Insurance Plan

Instructions

1. To be considered for coverage, you must have Medicare Parts A and B, reside in Texas, and be: a) age 65 or over or b) applying within 6 months of your Medicare Part B effective date.
2. **If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) on pages 3 and 4.** Send no money now! No payment is due until you have a chance to review your policy and make sure the coverage is right for you.
3. If you meet the eligibility requirements for under age 65 disability, you are only eligible for Plan A.

HOME OFFICE USE ONLY

Plan Selection *Check one box to apply for a Medicare Supplement Insurance plan.*

- ☐ **Plan A**
- **Plan F**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **Plan F High Deductible**
- **Plan G**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan K**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan L**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan N**
  - ☐ Standard
  - ☐ Medicare Select

Requested Policy Effective Date ☐☐ ☐☐ ☐☐☐☐ *MONTH DAY YEAR*

See the enclosed Outline of Coverage for rate information

Applicant Information

Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email

Name *(First)*	*(Middle)*	*(Last)*		
Home Address (No P.O. Boxes)		City	State **TX**	Zip
Correspondence/Billing Address		City	State	Zip
Primary Phone ( )	Secondary Phone ( )	Age	Date of Birth ___/___/___ Mo. Day Year	
Gender Male ☐ Female ☐	Social Security Number ___-___-___		Email address	

Payment Option *(Select one payment option)*

1. ☐ Premium **deducted from bank account**: *(choose one)*: ☐ ***Checking*** ☐ ***Savings***

Account holder name: _____

Bank name: _____

Bank routing #: _____ Bank account #: _____

Account Owner Signature *(if different than applicant)* **X** _____

2. ☐ Premium **to be billed by mail**

3. I will pay my premium: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Applicant Name _____

Medicare Claim Number

Please copy the Medicare Claim Number from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Part A Effective Date: ___/01/_____

Your Medicare Claim No. _____–_____–_____ *(if applicable)*

Part B Effective Date: ___/01/_____

Consumer Protection 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. Please mark Yes or No below with an "X" to the best of your knowledge.

1. Did you turn age 65 in the last 6 months? Yes ☐ No ☐

2. Did you enroll in Medicare Part B in the last 6 months? Yes ☐ No ☐

If yes, what is the effective date? ___/___/_____

3. 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 Cost," please answer NO to this question.* Yes ☐ No ☐

a. If yes, will Medicaid pay your premiums for this Medicare Supplement policy? Yes ☐ No ☐

b. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes ☐ No ☐

4. 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. *(If you are still covered under this plan, leave "END" blank.)*

Start: ___/___/_____

End: ___/___/_____

a. 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 ☐

b. Was this your first time in this type of Medicare plan? Yes ☐ No ☐

c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes ☐ No ☐

5. Do you have another Medicare Supplement or Medicare Advantage policy in force? Yes ☐ No ☐

a. If so, with what company, and what plan do you have? _____

b. If so, do you intend to replace your current Medicare Supplement or Medicare Advantage policy with this policy? Yes ☐ No ☐

6. Have you had coverage under any other health insurance within the past 63 days? Yes ☐ No ☐

a. If so, with what company, and what kind of policy?
(For example, an employer, union, or individual plan) _____

b. What are your dates of coverage under the other policy?
(If you are still covered under the other policy, leave "END" blank.)

Start: ___/___/_____

End: ___/___/_____

Applicant Name _____

STATEMENTS

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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.*
5. 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.

6. 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). For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

Questions?

Call us at our Customer Service toll-free number 1-888-731-0415, call your insurance agent at the number listed on the next page, or visit *www.bcbstx.com*.

Proxy Statement: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Applicant Signature *(optional)*: **X** _____

Print Your Name as You Signed It: _____ Date: ___ ___/___ ___/___ ___ ___ ___

Applicant Name _____

Acknowledgements and Signature

1. I hereby apply for coverage and request a policy to review for the Medicare Supplement policy indicated.
2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.
3. I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.
4. I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.
5. I acknowledge that I have read and understand the Statements section regarding Medicare Supplement coverage. If eligible for a Medicare Select Plan, I have also read and understand the statements regarding Medicare Select as described in the Outline of Coverage. WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

SIGNATURE REQUIRED

*Must be signed **in ink** and dated to avoid processing delays. For Power of Attorney and Legal Guardianships, be sure to submit copies of the court documents with the application.*

Applicant X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Agent Information *(If Applicable)*

The following statements apply if you are purchasing coverage through an agent:

- The undersigned acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
- The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, he/she should contact the agent.
- The applicant(s) have received a copy(s) of the Medicare Supplement Buyers Guide.

Any other health insurance policies or coverages sold to the applicant which are still in force:

_____

Any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

_____

I have reaffirmed that the information supplied on this application is accurate and complete.

Agent Signature: X _____ Date: ___ ___/___ ___/___ ___ ___ ___

Print name: Tiffany Jackson Broker Code: 046643000

Agency name *(If Applicable)*: CDA Insurance LLC Phone: (800) 884-2343

Please return completed application to your agent or:
Blue Cross Blue Shield of Texas, P.O. Box 3003, Naperville, IL 60566-7003

BlueCross BlueShield of Texas
P.O. Box 3003
Naperville, IL 60566-7003

Notice to Applicant Regarding

REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Blue Cross and Blue Shield of Texas. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, and acceptance by the replacing issuer, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY BLUE CROSS AND BLUE SHIELD OF TEXAS:

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- ❑ Additional benefits.
- ❑ No change in benefits, but lower premiums.
- ❑ Fewer benefits and lower premiums.
- ❑ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ❑ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment: _____

  _____
- ❑ Other (please specify): _____

1. Note: If the issuer of the Medicare supplement policy applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

	046643000
Agent's Signature	Agent's Number
Tiffany Jackson, PO Box 26540, Eugene, OR 97402	
Printed Name and Address of Agent	
Applicant's Signature	Date

Illinois
New Mexico
Oklahoma
Texas

Experience. Wellness. Everywhere.®

ezBlue℠ PAYMENT OPTION **Authorization Agreement**

Take these simple steps for hassle-free monthly premium payments:

- Verify with your financial institution that it can accept automated electronic withdrawals.
- Complete, sign and return this authorization form.
- If submitting by fax, please fax this form to **888-235-2949**.
- If submitting this form by mail, please use this address:

Medicare Supplement Membership
P.O. Box 3004
Naperville, IL 60566

If you have any questions about this program, please call our Customer Service Department toll-free at **1-800-624-1723**.

AGREEMENT

I request and authorize Blue Cross and Blue Shield (BCBS) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. This authorization will remain in effect until I notify BCBS or the Financial Institution in writing to terminate and BCBS or the Financial Institution has a reasonable time to act on the termination.

Please complete the following - Print or Type information

Deduct ongoing monthly premium payments from my designated checking or savings account. If the withdrawal date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. (Please note that coverage cannot be issued until the first month of premium has been received in our office, unless you have authorized BCBS to deduct the initial payment upon receipt of your application).

BCBS Member ID: _____

Name of Member: _____

Name of Depositor(s) if other than the member: _____

Phone number of Member/Depositor: _____

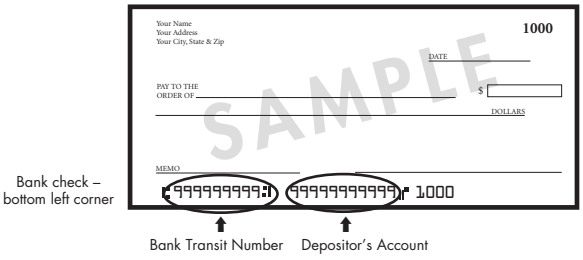
Name of Bank, City and State
where account is authorized: _____

_____

Please check one: ❑ Checking Account ❑ Savings Account

Bank Transit Number: _____

Depositor's Account Number: _____



I have read and accept the above agreement.

Please continue to pay your premiums by check or money order until you receive a confirmation letter from us stating the date automatic payments will begin.

Depositor's Signature: _____ Date: _____

Blue Cross and Blue Shield of Illinois, Blue Cross and Blue Shield of New Mexico,
Blue Cross and Blue Shield of Oklahoma, and Blue Cross and Blue Shield of Texas,
Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association

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