BlueCross BlueShield TX Packet (U-65)

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 Plan

1. Have your Medicare card and Social Security card available to fill in the required information below.

2. **Complete and sign the application in ink**, then mail it in the enclosed postage-paid envelope. **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.

For coverage to go into effect, you must be under age 65, reside in Texas and have Medicare Parts A and B. You must also apply within six (6) months of your Medicare Part B effective date, or qualify as an Eligible Person as defined in the Supplement to this Application. If you meet these conditions, Plan A is Guaranteed Issue.

A. Plan Selection

I would like to apply for:

☑ **Plan A**

Make policy effective: ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

See the enclosed Outline of Coverage for rate information.

B. Personal Information

Name_____

Address_____

City_____ County_____

State_____ ZIP_____

☐ Male ☐ Female

Your Birthdate ☐☐ MONTH ☐☐ DAY ☐☐☐☐ YEAR

Your Social Security No. ☐☐☐-☐☐-☐☐☐☐

C. Medicare Claim Number

Please see your Medicare card for this information.

Copy the Medicare Claim Number from your red, white and blue Medicare card. This number must be provided for us to complete your application process.

Your Medicare Claim No.

☐☐☐-☐☐-☐☐☐☐☐

(PLEASE INCLUDE ANY PREFIXES OR SUFFIXES)

Your Medicare:

Part A effective date ☐☐ MONTH 0 1 DAY ☐☐☐☐ YEAR

D. Consumer Protection Information

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?** . . . . . ☐ **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.*

   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**

(Continued on other side)

Signature

Must be signed and dated to avoid delays in processing. **I have read and understand the statements on the reverse side regarding Medicare Supplement coverage. I have received the appropriate Outline of Coverage.**

Signature: X _____ Date: ___/___/_____

Primary Phone (_____)_____ Secondary Phone (_____)_____

E-Mail Address _____

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 yes, with what company, and what plan do you have?

_____

b. If yes, do you intend to replace your current Medicare Supplement or Medicare Advantage 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 this plan, leave "END" blank.)*

Start: ___/___/_____

End: ___/___/_____

Important Information Regarding Medicare Supplement Coverage

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 more than one type of coverage in addition to your Medicare benefits. 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 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.*

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).

Please sign the signature line on the reverse side.

I hereby apply for coverage and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date shown on my Blue Cross and Blue Shield of Texas 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.

I hereby declare that the statements and answers on this application, including but not limited to those relating to age, are to the best of my knowledge and belief, complete and true, and I agree that Blue Cross and Blue Shield of Texas believing them to be true shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.

I understand any Medicare Supplement insurance carrier is required to offer a minimum of Plan A to those who are under the age of 65 and Medicare eligible due to disability. In order to be eligible, I am applying for this coverage with Blue Cross and Blue Shield of Texas within six (6) months of my Medicare Part B effective date; or I qualify as an eligible person as defined in the Supplement to this application, and I am applying for coverage no later than 63 days after the termination of prior coverage. I agree to pay the premium rate established for this coverage.

*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.

Questions? Call us toll-free at

1-888-731-0415

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: _____

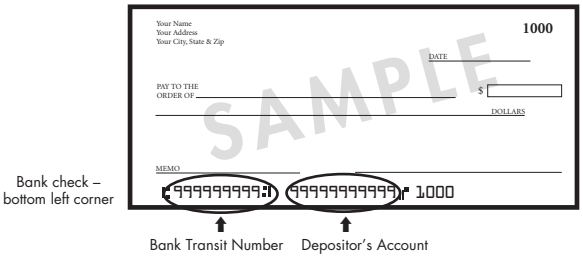
Name of Bank, City and State
where account is authorized: _____

_____

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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