Blue Cross of Idaho | Care Plus

Medicare Supplement Application

Applicant Information

Your Name *(first, initial, last)*	Date of Birth *(mm/dd/yy)*	Age	Height	Weight	❑ Male ❑ Female

Physical Address *(street or route)*	City, State, Zip Code	County

Mailing Address *(street or route)*	City, State, Zip Code	County

Billing Address *(if different from mailing address)*	City, State, Zip Code	County

Marital Status ❑ Single ❑ Married	Do you or have you ever smoked or used tobacco in the past 12 months? ❑ Yes ❑ No	Preferred Phone	Alternate Phone	❒ I don't have a phone

Are you applying during open enrollment? ❑ Yes ❑ No	Do you have Part A of Medicare? ❑ Yes ❑ No Effective Date_____ Do you have Part B of Medicare? ❑ Yes ❑ No Effective Date_____	Medicare Number

Are you currently enrolled with Blue Cross or Blue Shield? ❑ Yes ❑ No	If yes, Identification Number	Headquarters City and State	Social Security Number

Medicare Supplement plans are offered by Blue Cross of Idaho Care Plus, Inc. When this document says Blue Cross of Idaho Care Plus, it means Blue Cross of Idaho Care Plus, Inc.

Program Information

❑ ***Idaho MedPlus*** – Plan A ❑ ***Idaho MedPlus*** – Plan F ❑ ***Idaho MedPlus***– Plan K ❑ ***Idaho MedPlus***– Plan N

Requested Effective Date: _____

The effective date on the policy will be the first of the month following receipt and acceptance of the application by the Blue Cross of Idaho Underwriting Department.

If, after health statement review, I am not eligible for my selection marked above, please consider me for:

(First choice) _____ *(Second choice)* _____

❑ Do not enroll me. Please refund my payment.

Independent Producer Statement

- I hereby certify that I personally solicited and completed this application, that I personally asked each question on this application, and have accurately recorded the answers;
- That the answers to all of the questions are complete and accurate to the best of my knowledge and belief;
- That I have explained the eligibility provisions to the applicant and have not made any representations about benefits, conditions, or limitations of the policy, except through written material furnished by Blue Cross of Idaho Care Plus;
- That I have verified the dates on the applicant's Medicare card.

Type of Company Appointment: ❑ Personal ❑ Agency (Name) _____

_____ *Independent Producer's Printed Name*

_____ *Independent Producer's Signature*

_____ *Date*

_____ *Phone Number*

_____ *Blue Cross of Idaho No.*

Health Statement

(Please disregard if you are applying during Medicare initial enrollment period, have guarantee issue rights or if you currently have other Blue Cross of Idaho coverage and are applying for Idaho MedPlus Plan A.)

Answer each question YES or NO. If YES, ***circle*** the specific condition. Then, in the chart below, write the number or letter in which the condition is listed, along with specific details.

A. Has any company refused or restricted insurance on the applicant within the past year? ❑ **YES** ❑ **NO**

B. Has the applicant been advised, in the past five years, to have surgery or hospitalization? ❑ **YES** ❑ **NO**

C. Has the applicant ever had or been told he or she has any of the following:

	YES	NO
1. Cancer, cyst, tumor, or tumorous growth *(malignant or benign)* within past 20 years?	❑	❑
2. Heart trouble, heart murmur, chest pain, stroke or any other disorder of the blood or circulatory system within the past 20 years?	❑	❑
3. An ulcer or any disorder or difficulty of the stomach, liver, intestines or gall bladder within the past 10 years?	❑	❑
4. Diabetes, thyroid disorder or any disorder of the glands within the past 20 years?	❑	❑
5. Convulsions, loss of consciousness, or paralysis within the past 10 years?	❑	❑
6. Any disorder of the kidneys, bladder, or prostate within the past 10 years?	❑	❑
7. Disease or disorder of the eyes within the past 10 years?	❑	❑
8. Emphysema, tuberculosis or removal of any part of lung within the past 20 years?	❑	❑
9. Rheumatoid arthritis or osteoarthritis within the past 10 years?	❑	❑
10. A physical examination, check-up or doctor's visit within the past six months?	❑	❑
11. High blood pressure within the past 10 years? *(If **YES,** last reading _____)*	❑	❑
12. Has the applicant ever tested positive for HIV infection within the past 20 years?	❑	❑
13. Does the applicant have any illness, condition or irregular symptoms not named above within the past 20 years?	❑	❑

If you answered YES to any question above, please explain below. Use extra paper if needed.

Item No.	Diagnosis	Type of Treatment	Date of Illness	Date of Last Visit	Was Recovery Complete?

List any medications or drugs taken by all applicants within the past 12 months. Use extra paper if needed.

Item No.	Medication Name (Dosage)	Condition Requiring Medication	Still Taking?

– FOR AGENT USE ONLY –

List policies you have sold to this applicant that are still in force. *(Use extra sheet of paper if needed.)*

_____

_____

List policies you have sold to this applicant in the past five years that are no longer in force. *(Use extra sheet of paper if needed.)*

_____

_____

Other Coverage

To the best of your knowledge:

1. Do you currently – or have you had in the past – another Medicare supplement policy or certificate in force *(including any health care service contract or health maintenance organization contract)?* ❑ **YES** ❑ **NO**

   (a) If **YES**, with which company? _____

   (b) In what state? _____

   (c) What was the termination date of the policy? _____

   (d) What plan? (A-N) _____

2. Do you have any other health insurance policies or certificates? ❑ **YES** ❑ **NO**

   (a) If **YES**, with which company? _____

   (b) What kind of policy or certificate? _____

3. If the answer to question 1 or 2 is **YES**, do you intend to replace these policies or certificates with this policy? ❑ **YES** ❑ **NO**

4. Are you covered by Medicaid? ❑ **YES** ❑ **NO**

Statement of Understanding

- I understand and agree that the statements and answers on this Application and Health Statement are complete and accurate, and that any false statement, misrepresentation, or concealment of fact may, at the option of Blue Cross of Idaho Care Plus, bar recovery of any benefits, and shall be grounds for voidance or cancellation of the policy.
- I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***idahomedplus.com.***
- I understand and agree that the deposit, $ _____ *(if any),* submitted with the Application is not binding upon Blue Cross of Idaho Care Plus for the benefits applied for herein until the Application is approved; after approval the deposit then is payment of premiums for _____ month(s) from the effective date.
- The "Notice to Applicant" and *Outline of Coverage* were furnished to me on _____ (*Date)*

Applicant's Signature _____ Date _____

Other Carrier Information

Blue Cross of Idaho Care Plus is currently considering a Medicare supplement application for the insured named below. The policy may or may not replace an existing Medicare supplement policy.

Insurer _____ Name of Insured: _____

Name _____ _____

and _____ _____

Address: _____ _____

_____ _____

Other Carrier _____ Policy Number: _____

For Independent Producers Only

Independent Producer Checklist

- ❑ Are the Medicare Part A and B effective dates filled in on the first page?
- ❑ Is the application completed in ink and signed by the applicant? (A dependent's signature is not acceptable.)
- ❑ Are all questions marked "yes" or "no?" (Check to make certain that specific condition(s), date(s) of occurrence, or date(s) last treated is (are) included and note if condition(s) is (are) resolved; make certain that condition explanation is complete; include prescription name, dosage, strength, duration and reason; if there are broken bones, are there any pins or hardware?)
- ❑ Is the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance section signed and dated?
- ❑ Did the applicant indicate the program they are applying for? (Only one program is allowed.)
- ❑ Are height and weight noted for the applicant listed on the application?
- ❑ Is the requested effective date on the first page filled in?
- ❑ Are all payments attached to the front of the application?
- ❑ If one check is written for split applications, is a breakdown of amounts to apply to each application included?
- ❑ Does the payment include a $2 monthly billing fee if the applicant chose Monthly Direct Coupon?
- ❑ Did you verify eligibility on applicant's card?

Independent Producer Certification

1. Who actually completed this application? ❑ Applicant ❑ Independent Producer ❑ Other

   If Independent Producer or Other, please explain: _____

2. Were you present at the time the application was filled out? ❑ **YES** ❑ **NO**

   If **NO**, please explain: _____

3. Are you aware of any medical information relating to the applicant or any family member that has not been disclosed on this application? ❑ **YES** ❑ **NO**

   If **YES**, please explain: _____

4. Was money collected from the applicant? ❑ **YES** ❑ **NO** **Amount $**_____

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions or limitations of the policy except through written material furnished by Blue Cross of Idaho Care Plus. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

_____	_____	_____
Independent Producer's Printed Name	*Independent Producer's Signature*	*Date*
_____	_____	
Phone Number	*Blue Cross of Idaho No.*	

Type of Company Appointment ❑ *Personal* ❑ *Agency (Name)*_____

OFFICE USE ONLY

Nondiscrimination Statement: Discrimination is Against the Law

Blue Cross of Idaho complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Blue Cross of Idaho does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Blue Cross of Idaho:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Blue Cross of Idaho's Customer Service Department. Call 1-888-494-2583 (TTY: 1-800-377-1363), or call the customer service phone number on the back of your card.

If you believe that Blue Cross of Idaho has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with Blue Cross of Idaho's Grievances and Appeals Department at:

Manager, Grievances and Appeals
3000 East Pine Avenue, Meridian, Idaho 83642
Telephone: (800) 274-4018 ext.3838, Fax: (208) 331-7493
Email: grievances&appeals@bcidaho.com
TTY: 1-800-377-1363

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Grievances and Appeals team is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ***https://ocrportal.hhs.gov/ocr/portal/lobby.jsf***, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TTY). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***. Reference: ***https://federalregister.gov/a/2016-11458***

ATTENTION: If you speak Arabic, Chinese, French, German, Korean, Japanese, Persian (Farsi), Romanian, Russian, Serbo-Croatian, Spanish, Sudanic Fulfulde, Tagalog, Ukrainian, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-888-494-2583 (TTY: 1-800-377-1363).

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1- 888-494-2583 (رقم هاتف الصم والبكم: 1-800-377-1363).

Chinese 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-494-2583（TTY：1-800-377-1363）。

French ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1- 888-494-2583 (ATS : 1-800-377-1363).

German ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1- 888-494-2583 (TTY: 1-800-377-1363).

Japanese 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1- 888-494-2583（TTY: 1-800-377-1363）まで、お電話にてご連絡ください。

Korean 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1- 888-494-2583 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Persian-Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت اریگان برای شما فرا مهم می باشد. با 1 888-494-2583 (TTY: 1-800-377-1363) تماس بگیرید.

Romanian ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1- 888-494-2583 (TTY: 1-800-377-1363).

Russian ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1- 888-494-2583 (телетайп: 1-800-377-1363).

Serbo-Croation OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1- 888-494-2583 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-377-1363).

Spanish ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1- 888-494-2583 (TTY: 1-800-377-1363).

Sudanic Fulfulde MAANDO: To a waawi [Adamawa], e woodi ballooji-ma to ekkitaaki wolde caahu. Noddu 1- 888-494-2583 (TTY: 1-800-377-1363).

Tagalog PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1- 888-494-2583 (TTY: 1-800-377-1363).

Ukrainian УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1- 888-494-2583 (телетайп: 1-800-377-1363).

Vietnamese CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-494-2583 (TTY: 1-800-377-1363).