Blue Cross of Idaho | Care Plus

PERSI Authorization Form for Retiree Medicare Supplement Coverage

RETIREE INSTRUCTIONS: Please complete, sign and return to Blue Cross of Idaho.

Retirees over the age of 65 must be enrolled in Part A and Part B of Medicare.

I am a State of Idaho: ❑ **New retiree** ❑ **Current retiree requesting a change to coverage** ❑ **Retiree requesting payment for my spouse**	**I am a Statewide Schools:** ❑ **New retiree** ❑ **Current retiree requesting a change to coverage** ❑ **Retiree requesting payment for my spouse**	
Retiree's Name	Current Blue Cross ID Number	Birthdate
Address	City, State, Zip Code	
Social Security Number	Medicare Beneficiary Number	
Phone Number	Date of Retirement	
Spouse's Name (if requesting payment for your spouse)	Spouse's Social Security Number	
Spouse's Medicare Beneficiary Number	Spouse's Date of Birth	

Blue Cross of Idaho will contact PERSI for permission to access your funds. **You are responsible for paying your premium until PERSI begins paying the monthly plan premium on your behalf.**

Retiree's Signature: ____ **Date:**

When applying for a Medicare Supplement plan, return this form to:
Blue Cross of Idaho
Box 7408
Boise ID 83707-9984

3000 E. Pine Ave. • Meridian, Idaho 83642 • 1-800-GO-CROSS (1-800-462-7677)
Mailing Address: P.O. Box 7408 • Boise, ID 83707-1408

© 2017 An independent licensee of the Blue Cross and Blue Shield Association, with services provided by Blue Cross of Idaho

Form No. 4-161 (01-17)