

**FOR OFFICE USE ONLY**

Accept. Code \_\_\_\_\_  
 Plan Type \_\_\_\_\_  
 Market Code \_\_\_\_\_

# Blue Shield of California Application to Transfer to a Medicare Supplement Plan



**Blue Shield  
 of California**  
 An Independent Member  
 of the Blue Shield Association

**TRANSFERRING IS AS EASY AS 1-2-3!**

1. Provide ALL requested information and print clearly in ink. Sign and date at the end.
  2. Within 30 days of your signature date, mail the application in the postage-paid envelope enclosed. Keep the yellow copy for your records.
  3. Please submit your payment along with your application.
- If you have questions about how to enroll, please call us at **(888) 713-0000** [TDD: (888) 595-0000].

You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at **(800) 434-0222** for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

**PERSONAL INFORMATION**

First Name		Middle Initial	Last Name	
Home Address				
City			State	Zip
Home Telephone (     )		E-mail		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing Address (if different from above)				
City			State	Zip
Date of Birth ____ - ____ - ____ MONTH      DAY      YEAR		Language Preference <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Chinese <input type="checkbox"/> Other _____		
Please name the plan type you are applying for:				
Requested Effective Date: The <input type="checkbox"/> 1st day or <input type="checkbox"/> 15th day of ____ - ____ <div style="text-align: center;">MONTH                  YEAR</div>				
Medicare Number		Social Security Number		
Blue Shield Member Number				
Medicare Hospital (Part A) Effective Date _____			Medicare (Part B) Effective Date _____	

**MEDICARE PRESCRIPTION DRUG PLAN INFORMATION**

<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you purchased a Medicare Prescription Drug Plan? IF YES, a.) With what company? b.) What is the effective date?
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**GUARANTEED ACCEPTANCE**

You are guaranteed acceptance into a Medicare Supplement plan under Situation #1 as described in Blue Shield's Guaranteed Acceptance (GA) Guide, if you are within 6 months of your 65th birthday and your Part B effective date, or if you already have Medicare because you are disabled and have just turned 65. If you don't qualify for Situation #1, you may qualify for other GA situations that are listed in Blue Shield's GA Guide. Please read this guide and complete the statement below:

**I believe I qualify for guaranteed acceptance based on situation number \_\_\_\_\_ .**

## PAYMENT INFORMATION

To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement Plans Summary of Benefits and Provisions. Unless you participate in Automatic Payment (Easy\$Pay or credit card payment), you will receive a bill indicating the amount and the date your next payment is due.

If you have or want to enroll in Automatic Payment:

- I already participate in Automatic Payment, and would like to continue my authorization for premium payments by automatic charge/debit for the rate applicable to the new plan identified above, if my application to transfer is approved.
- I would like to enroll in Automatic Payment for automatic charge/debit of dues. (You must complete the enclosed form).

## CURRENT HEALTH PLAN INFORMATION

PLEASE ANSWER ALL QUESTIONS. (Please mark Yes or No below with an "X.")

To the best of your knowledge,

1.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	a.) Did you turn 65 years of age 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? _____
2.	<input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you covered for medical assistance through California's Medi-Cal program? <b>NOTE TO APPLICANT:</b> If you have a share of cost under the Medi-Cal program, please answer NO to this question. a.) Will Medi-Cal pay your premiums for this Medicare supplement contract? b.) Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?
3.	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	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 _____ a.) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract? b.) Was this your first time in this type of Medicare plan? c.) Did you drop a Medicare supplement contract to enroll in the Medicare plan?
4.	<input type="checkbox"/> Yes <input type="checkbox"/> No IF YES, <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have another Medicare supplement policy or certificate or contract in force? a.) With what company, and what plan do you have? b.) Do you intend to replace your current Medicare Supplement policy or certificate with this contract?
5.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? If so, what companies and what kind of policy? _____ _____ What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) Start _____ End _____

## TERMS, CONDITIONS AND AUTHORIZATIONS

**Information Regarding Medicare Supplement Coverage:** Before you apply, it's important that you read the following information, then sign and date at the end of this application.

- You do not need more than one Medicare Supplement plan policy or contract.
- If you purchase a Blue Shield Medicare Supplement Plan contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement plan policy or contract.
- If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

**TERMS, CONDITIONS AND AUTHORIZATIONS, continued**

5. If you are eligible for, and have enrolled in, a Medicare supplement contract 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 contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract 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 are available in California to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

**Conditions of Membership:**

1. This application will become part of the Evidence of Coverage for which I am applying, and together with any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2. I will receive no coverage from Blue Shield unless Blue Shield’s Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3. Only Blue Shield can approve this application. I understand that any insurance agent, broker or Sales Representative cannot grant approval, change terms or waive requirements.

**I acknowledge receipt of the Summary of Benefits, the “Guide to Health Insurance for People with Medicare” and a copy of this application. I have read the Summary of Benefits and the terms, conditions and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.**

Applicant’s Signature

Date

Authorization for Disclosures of Personal Information: I authorize any “provider of care,” insurer or health plan to disclose to Blue Shield of California, or its representatives, and vice versa, all “medical information” (as those terms are defined in the California Civil Code) regarding me, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review, and administrative functions reasonably related to executing and managing this Agreement. This authorization will remain valid as follows for the term of the coverage or for as long as may be necessary for processing of claims incurred during coverage. I understand that I am entitled to a copy of this application and that a photocopy is as valid as the original.

Applicant’s Signature

Date

**REPRESENTATIVE INFORMATION**

Agent/Broker Name		Agent/Broker ID
Agent/Broker Phone #	Agent/Broker Fax #	
Agent/Broker Address		
Agent/Broker Signature		
List all policies and plan contracts sold that are still in force: _____		
List all policies and plan contracts sold in the past five (5) years that are no longer in force: _____		
_____		

White copy: Give to your Blue Shield Agent or mail to Blue Shield’s Underwriting Department with your first payment.  
Yellow copy: Keep with your important Blue Shield documents and information.