

Section 2 – Health History

You must already be enrolled in Medicare Parts A and B to apply for these plans. All applicants must complete sections 3 and 4. If the answer to any of the following questions is “Yes”, you are not eligible for coverage. However, we will not deny coverage to any individual who is subject to and applies for coverage during any open enrollment period, or to any individual who qualifies for guaranteed issue coverage. We will not deny coverage to any individual who applies for coverage if you are applying from certain Blue Cross Plans that are not Medicare Supplements or you are 65 or older and applying within six (6) months of your initial enrollment in Medicare Part B. You must already be enrolled in Medicare Parts A and B to apply for these plans.

Applicant must complete this section.

- | | Yes | No |
|---|--------------------------|--------------------------|
| A. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements.) | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin's disease, coronary artery disease, heart attack, nephritis, kidney failure, stroke or brain disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Within the past 5 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, organ transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight? | <input type="checkbox"/> | <input type="checkbox"/> |

Section 3 – Medical Information

Name of Primary Care Physician _____ Telephone (_____) _____

Address _____

List all prescription drugs currently prescribed for your use: (If none, write “none”) _____

List name, address and telephone number of prescribing physician if different from above:

If applying for, but not accepted for **Blue Cross Senior Classic I** or **Blue Cross Senior Classic J**,

if I qualify, I would like to be enrolled in: **Blue Cross Senior Classic F** or

Blue Cross Senior Classic C

Section 4 – General 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.

To the best of your knowledge:

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

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

C. If yes, what is the effective date? ____/____/____

D. Are you covered for medical assistance through California's Medi-Cal program?

NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question. Yes No

If yes,

i. Will Medi-Cal pay your premiums for this Medicare supplement policy? Yes No

ii. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium? Yes No

E. 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 ____/____/____

i. 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

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

iii. Did you drop a Medicare supplement policy to enroll in this Medicare plan? Yes No

F. Do you have another Medicare supplement policy in force? Yes No

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

ii. If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No

G. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes No

i. If so, with what company and what kind of policy? _____

ii. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. START ____/____/____ END ____/____/____

Please be aware that if you currently enrolled in a Medicare Risk HMO plan, including Blue Cross Senior SecureSM, it is your responsibility to terminate your coverage prior to enrollment becoming effective with Blue Cross. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.

Please read the following carefully.

- A. I agree to pay an application fee equal to the subscription charges required for the program requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the subscription charges if my application is accepted.
- B. Blue Cross has the right to reject my application. If Blue Cross rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if Blue Cross rejects my application, under no circumstances will any Blue Cross benefits be payable. ***Cashing of my check by Blue Cross does not constitute approval of my application.***
- C. If my application is accepted, this application will become part of the agreement between Blue Cross and myself. If this application is accepted, I further agree to be bound by the binding arbitration clause set forth in this application and I waive my right to court trial by judge or jury in the event of any dispute arising under this policy.
- D. Blue Cross may request additional information, which may delay processing of this application. If the health care provider bills for this information, Blue Cross will pay up to \$25 and I understand that I will be responsible for any difference.
- E. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or terms of any Blue Cross coverage.
- F. I alone am responsible for reading and accurately completing this application. I understand that coverage under the contract will be voided only in the event that I fail to accurately respond to questions regarding my past or present health condition. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted and that Blue Cross may void all coverage from the original effective date of the policy only in the event that I failed to accurately respond to questions regarding my past or present health conditions.
- G. **California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.**

Important Information for Applicant (Please read)

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 multiple coverages.
3. You may be eligible for benefits under Medi-Cal or Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing the policy, you become eligible for Medi-Cal or Medicaid, the benefits and premiums under your Medicare supplement policy 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 policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
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 reinstated if requested within 90 days after 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 reinstated 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 Medi-Cal or Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the California Department of Aging.

Section 6 – Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. The Member and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

The Member and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member. The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings. The arbitration is initiated by the Member making written demand on Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Blue Cross, or by order of the court, if the Member and Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Blue Cross will assume all or a portion of the costs of the arbitration. Please send all Binding Arbitration demands in writing to:

Blue Cross of California
P.O. Box 9063, Oxnard, CA 93031-9063

X

Applicant's Signature

Date of Signature

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex), but not including psycho therapy notes.

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker, for the purpose(s) described below.

Purpose of this Authorization: By signing this form, I will authorize you to use and/or disclose my Protected Health Information (PHI) to determine if I will be enrolled in your health plan, eligible for benefits, underwriting, risk rating my enrollment or eligibility. This authorization is a condition of my enrollment in your health plan or my eligibility for benefits.

Effect of Declining: If I decide not to sign this authorization, you may decline to enroll me in your health plan. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon termination of any Blue Cross coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

**Blue Cross of California
PO. Box 9063, Oxnard, CA 93031-9063
Telephone 1-800-333-3883, Fax 1-805-375-0361**

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

X

Print Name

X

Signature

Date

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free 1-800-927-HELP, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free 1-800-434-0222, or by accessing the Department of Insurance's web site www.insurance.ca.gov.

For Agent Only

Please list all disability policies you have issued to the applicant that are still in force and all disability policies issued in the past 5 years that are no longer in force and submit with the application, as required by Insurance Code Section 10197(c):

Date	Name of Policy	Name and Address of Insurance Company
From: Mo./Yr.		<div style="border-bottom: 1px solid black; margin-bottom: 2px;">Name</div> <div style="border-bottom: 1px solid black; margin-bottom: 2px;">Address</div> <div style="border-bottom: 1px solid black;">City/State</div>
To: Mo./Yr.		

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the applicant the "Guide to Health Insurance for People with Medicare" and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

	SIGNED AT	
Agent's Signature	Date of Signature	(City and State)
Print Agent's Name	Agent No.	
Street Address	Telephone No.	
City	State	ZIP
Amount Paid With Application \$ _____		
Send Agreement and I.D. Card To: <input type="checkbox"/> Agent <input type="checkbox"/> Subscriber		
Name of person who completed this application: _____		

Optional Monthly Checking Account Deduction Authorization for Seniors.

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Subscriber	
Group Number	
X	Date

Social Security Number	
Bank Name	
X	Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

Section 8 – Authorization & Agreements

The following authorization is voluntary.

Only complete the section below if you wish to disclose your Private Health Information (PHI) to a third party (spouse, family member, or any other individual). Signing this form will allow a third party the ability to call for information regarding your application or claims.

SECTION A: Individual authorizing use and/or disclosure

Name _____ Telephone _____

Address _____ Member Identification Number _____

SECTION B: The use and/or disclosure being authorized

PHI to be Used and/or Disclosed: **(Specifically describe the PHI to be used and/or disclosed)**

Check if this authorization is for psychotherapy notes.

If this authorization is for psychotherapy notes, you must not use it as an authorization for any other type of protected health information (PHI).

Entities or Persons Authorized to Use or Disclose: (Name or specifically describe the persons and/or organizations (or the classes of persons and/or organizations), including us, who are authorized to make use of and/or to disclose the PHI described above).

Blue Cross _____

Entities of Persons Authorized to Receive: (Name or specifically identify the persons and/or organizations {or the classes of persons and/or organizations}, including us, who are authorized to receive, and subsequently use and/or disclose the PHI described above).

Blue Cross _____

Purpose of this Authorization:

At request of individual

For the following purposes:

No Conditions: This authorization is voluntary. We will not condition your enrollment in a health plan, eligibility for benefits or payment of claims on giving this authorization.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it may no longer be protected under the HIPAA Privacy Rule.

SECTION C: Expiration and revocation

Expiration: This authorization will expire (complete one)

On _____ / _____ / _____

On occurrence of the following event (which must relate to the individual or to the purpose of the use and/or disclosure being authorized).

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to the Contact Office listed below. I understand that revocation of this authorization will not affect any action you took in reliance on this authorization before you received my written notice of revocation.

Blue Cross of California

Contact Office

1-800-333-3883

1-805-499-3763

Telephone

Fax

P.O. Box 9063 Oxnard, CA 93031-9063

Address

INDIVIDUAL’S SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this form, I am confirming my authorization of the use and/or disclosure of my protected health information, as described in this form.

Print Name

Signature

Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative’s Name

Signature

Date

Relationship to Individual

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

THIS APPLICATION WILL BE RETURNED TO YOU AFTER PROCESSING.

WE ADVISE YOU TO SAVE THIS NOTICE AS IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to the information you have furnished, you intend to lapse or otherwise terminate an existing Medicare supplement policy or Medicare Advantage plan and replace it with a contract to be issued by Blue Cross of California. Your plan contract to be issued by Blue Cross of California will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Standard Plan A or Medicare Select coverage is a wise decision.

Statement to applicant by plan, solicitor, solicitor firm, or other representative:

- A.** You have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of your knowledge. The replacement contract is being purchased for the following reason (check one):
- 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 Medicare Part D.
 - Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
-
- Other. (Please specify.) _____
- B.** You may not be immediately eligible for full coverage under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present policy or contract.
- C.** State law provides that your replacement Medicare Select or Standard Plan A contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
- D.** If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and refund your prepaid or periodic payment as though your contract had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.
- E.** Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.



Blue Cross Senior Services Toll-Free Number

Monday – Thursday:
8:00 a.m. to 6:00 p.m.

Friday:
8:00 a.m. to 3:00 p.m.

1-800-333-3883

MAILING ADDRESS – Applicant: Please return application to agent or mail to:

Blue Cross of California
P.O. Box 9063, Oxnard, CA 93031-9063

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