BlueCross of Idaho Application Packet

Thank you for your interest in applying for the Blue Cross of Idaho Medicare Supplement plan!

This application packet provides you with access to a printable copy of the Enrollment Form and the Outline of Coverage in addition to a link to the Choosing a Medigap Policy Guide.

Should you decide to apply by secure upload/mail/fax/email, the printable application needs to be reviewed and signed by an Agent before it can be submitted to Blue Cross of Idaho. You may upload, email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: cs@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) Download Policy Outline (.pdf) Download Policy Application (.pdf)

Our website: http://www.medicare-idaho.com

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Blue Cross of Idaho **MEDICARE**

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 FOR IDAHO MEDPLUS

❑ *MedPlus* – Plan A ❑ *MedPlus* – Plan F (for those eligible for Medicare prior to January 1, 2020) ❑ *MedPlus* – Plan G

❑ *MedPlus* – Plan K ❑ *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 Care Plus 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 any payment made.

IMPORTANT INFORMATION BEFORE YOU APPLY

You do not need more than one (1) Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. 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 twenty-four (24) months. You must request this suspension within ninety (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 ninety (90) days of losing 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. 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 ninety (90) days of losing your employer or union-based 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services are available through the Senior Health Insurance Benefit Advisors program (SHIBA), 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).

HEALTH STATEMENT

(Please disregard if you are applying during Medicare initial enrollment period OR have guaranteed issue rights.)

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.

Has the applicant had or been told he or she has any of the following within the past five years:

1. Cancer, cyst or tumor (malignant or benign)? ❑ Yes ❑ No	8. Parkinson's, multiple sclerosis (MS), or amyotrophic lateral sclerosis (ALS)? ❑ Yes ❑ No
2. Heart trouble, chest pain, stroke, hemophilia or any other disorder of the blood or circulatory system? ❑ Yes ❑ No	9. Emphysema, tuberculosis (TB) or removal of any part of the lung? ❑ Yes ❑ No
3. High blood pressure or heart murmur? ❑ Yes ❑ No	10. Rheumatoid arthritis or osteoarthritis? ❑ Yes ❑ No
4. End stage renal disease, dialysis, chronic hepatitis, cirrhosis or any other disorder of the kidney, liver, or intestines? ❑ Yes ❑ No	11. HIV infection or AIDS? ❑ Yes ❑ No
5. Diabetes or thyroid disorder? ❑ Yes ❑ No	12. Amputations or prosthetic devices? ❑ Yes ❑ No
6. Epilepsy, convulsions, Alzheimer's disease, dementia, loss of consciousness or any other cognitive disorder? ❑ Yes ❑ No	13. Any illness, condition or irregular symptoms not named above? ❑ Yes ❑ No
7. Organ transplant or any disorder of the stomach, bladder or prostate? ❑ Yes ❑ No	14. Advised to have surgery or hospitalization that has not yet been performed? ❑ Yes ❑ No

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 applicant 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 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.
To the best of your knowledge:

1. Did you turn 65 in the last six (6) months? ❑ YES ❑ NO
2. Did you enroll in Medicare Part B in the last six (6) months? ❑ YES ❑ NO
   (a) If YES, what 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.
4. Will Medicaid pay your premiums for this Medicare Supplement policy? ❑ YES ❑ NO
5. Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ❑ YES ❑ NO
6. If you had coverage from any Medicare plan other than original Medicare within the past sixty-three (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 until this plan, leave "END" blank.
   Start date: _____ End date: _____
7. 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
8. Was this your first time in this type of Medicare plan? ❑ YES ❑ NO
9. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ❑ YES ❑ NO
10. Do you have another Medicare Supplement policy in force? ❑ YES ❑ NO
    (a) If so, with what company?_____ What plan do you have?_____
    (b) If so, do you intend to replace your current Medicare Supplement policy with this policy? ❑ YES ❑ NO
11. Have you had coverage under any other health insurance within the past sixty-three (63) days? ❑ YES ❑ NO
    (a) If so, with what company and what kind of policy? _____
    (b) What are your dates of coverage under the other policy? _____

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 healthcare 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 Care Plus 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 _____

INDEPENDENT PRODUCER (AGENT) 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 $_____

5. List any other health insurance policies you have sold to the applicant.
   a. List policies sold which are still in force:_____
   b. List policies sold in the past five (5) years which are no longer in force:_____

- 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 member ID card.
- I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

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

Tiffany Jackson	008145BC
Agent's Name	ID No.
Signature of Agent	Date

Blue Cross of Idaho MEDICARE

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 information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross of Idaho Care Plus, Inc. Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or 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 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'm enrolling in Part D.
- ❑ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

_____

- ❑ Other (please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to completely and accurately 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 company to deny any future claims and to refund your premium as though your policy had never been in effect. ***After the application has been completed and before you sign it, 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.

_____ Tiffany Jackson PO Box 26540, Eugene, OR 97402

Signature of Agent, Broker or Other Representative — *Printed name and address of Insurer, Agent or Broker*

_____ _____

Applicant's Signature — *Date*

3000 E. Pine Ave. • Meridian, Idaho 83642 • 800-627-1188 | Mailing Address: P.O. Box 7408 • Boise, ID 83707-7408

DISCRIMINATION IS AGAINST THE LAW

Blue Cross of Idaho and Blue Cross of Idaho Care Plus, Inc. (collectively referred to as 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 Customer Service Department. Call 1-800-627-1188 (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 E. Pine Ave., Meridian, ID 83642
Telephone: 1-800-274-4018 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***.

ATTENTION: If you speak Arabic, Bantu, Chinese, Farsi, French, German, Japanese, Korean, Nepali, Romanian, Russian, Serbo-Croatian, Spanish, Tagalog, or Vietnamese, language assistance services, free of charge, are available to you. Call 1-800-627-1188 (TTY: 1-800-377-1363).

Arabic:
ملحوظة: إذا كنت تتحدث العربية اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1188-627-800-1 (رقم هاتف الصم والبكم:1363-377-800-1).

Bantu:
ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 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 1-800-627-1188（TTY：1-800-377-1363）。

Farsi:
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با1188-627-800-1 تماس بگیرید. (TTY: 1-800-377-1363)

French:
ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 1-800-377-1363).

German:
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (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。1-800-627-1188（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. 1-800-627-1188 (TTY: 1-800-377-1363)번으로 전화해 주십시오.

Nepali:
ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टेटिवाइ: 1-800-377-1363) ।

Romanian:
ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 1-800-377-1363).

Russian:
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 1-800-377-1363).

Serbo-Croatian:
OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-627-1188 (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 1-800-627-1188 (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 1-800-627-1188 (TTY: 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 1-800-627-1188 (TTY: 1-800-377-1363).