# 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<br>PO Box 26540<br>Eugene, Oregon 97402

| Other Important Information |
| --- |
| Download Medicare's Choosing a Medigap Policy Guide (.pdf)<br>Download Policy Outline (.pdf)<br>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.

# Medicare Supplement Application

Fold and tear along dotted line to detach pages for mailing

## APPLICANT INFORMATION

| Your Name (first, middle initial, last) | | Date of Birth | Age | ☐ Male ☐ Female |
|---|---|---|---|---|
| Physical Address (street or route) | | City, State, Zip Code | | County |
| Mailing Address (if different than physical address) | | City, State, Zip Code | | County |
| Billing Address (if different from physical address) | | City, State, Zip Code | | County |
| Preferred Phone | Alternate Phone | Email Address (Optional)* | | |
| Social Security Number | | Medicare Number | | |
| Marital Status ☐ Single ☐ Married | Do you now or have you ever smoked or used tobacco in the past 12 months? ☐ Yes ☐ No | | | |
| Do you have Part A of Medicare? ☐ Yes ☐ No Effective Date________________ | | Do you have Part B of Medicare? ☐ Yes ☐ No Effective Date________________ | | |

*By providing us with your email address you are agreeing to receive communications regarding your plan benefits and well-being. You can opt out at any time.

## CONFIRM THE PLAN YOU ARE APPLYING FOR BY CHECKING THE BOX BELOW:

☐ MedPlus – Plan A ☐ MedPlus – Plan F (For those eligible for Medicare prior to January 1, 2020)
☐ MedPlus – Plan G ☐ MedPlus – Plan G, High Deductible

Requested Effective Date:_________________

The effective date on the policy will be the first of the month following receipt and acceptance of the application by Blue Cross of Idaho Care Plus, Inc. or the requested effective date, whichever comes later.

You may be eligible for a lower premium if another person that currently has a Blue Cross of Idaho Medicare Supplement plan resides at the same address.

☐ I live with a person who's currently covered under a Blue Cross of Idaho Medicare Supplement plan.

Name of Covered Person:_____________________ Enrollee ID Number: _____________________

☐ I live with a person who is in the process of applying for a Blue Cross of Idaho Medicare Supplement plan.

Name of Covered Person:_____________________ Enrollee ID Number: _____________________

☐ I do not currently live with another person who has a Blue Cross of Idaho Medicare Supplement plan, and am not eligible for the household discount.

## 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).

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## 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. PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge:

1. (a) Did you turn 65 in the last six (6) months? ☐ Yes ☐ No
   (b) Did you enroll in Medicare Part B in the last six (6) months? ☐ Yes ☐ No
   (c) If YES, what is the effective date?
2. 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.

If YES:

   (a) Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No
3. (a) Did you have 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)?
      (i) If so, with what company and what kind of policy? ______________________
      (ii) What are your dates of coverage under the other policy? ______________________
      (iii) List the full member ID number as printed on your member ID card. ______________________
   (b) 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
   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
4. (a) Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No
   (b) If so, with what company?______________ What plan do you have? ______________
   (c) If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No
5. Have you had coverage under any other health insurance within the past sixty-three (63) days (for example, with an employer, union, or individual plan)? ☐ Yes ☐ No
   (a) If so, with what company and what kind of policy? ______________________
   (b) What are your dates of coverage under the other policy? ______________________
   (c) List the full member ID number as printed on your member ID card. ______________________

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## HEALTH STATEMENT

Please disregard if you are applying during Medicare initial enrollment period (within six months of your plan B effective date) or have federal/state guarantee issue rights.

Height__________________ Weight__________________

Answer each question Yes or No. If Yes, in the chart below, write the item number along with specific condition 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)?<br>☐ Yes ☐ No | 8. Parkinson's, Multiple Sclerosis (MS) or Amyotrophic Lateral Sclerosis (ALS)?<br>☐ Yes ☐ No |
| 2. Heart trouble, chest pain, stroke, hemophilia or any other disorder of the blood or circulatory system?<br>☐ Yes ☐ No | 9. Emphysema, tuberculosis (TB) or removal of any part of the lung?<br>☐ Yes ☐ No |
| 3. High blood pressure or heart murmur?<br>☐ Yes ☐ No | 10. Rheumatoid arthritis or osteoarthritis?<br>☐ Yes ☐ No |
| 4. End-stage renal disease, dialysis, chronic hepatitis, cirrhosis or any other disorder of the kidney, liver or intestines?<br>☐ Yes ☐ No | 11. HIV infection or AIDS?<br>☐ Yes ☐ No |
| 5. Diabetes or thyroid disorder?<br>☐ Yes ☐ No | 12. Amputations or prosthetic devices?<br>☐ Yes ☐ No |
| 6. Epilepsy, convulsions, Alzheimer's disease, dementia, loss of consciousness or any other cognitive disorder?<br>☐ Yes ☐ No | 13. Any illness, condition or irregular symptoms not named above?<br>☐ Yes ☐ No |
| 7. Organ transplant or any disorder of the stomach, bladder or prostate?<br>☐ Yes ☐ No | 14. Advised to have surgery or hospitalization that has not yet been performed?<br>☐ Yes ☐ No |

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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? |
|---|---|---|---|---|---|
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

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? |
|---|---|---|---|
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |
| | | | ☐ Yes ☐ No |

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## 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 healthcare 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 medicare.bcidaho.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 __________________

FOR AGENT USE ONLY

## 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. (a) List policies you have sold the applicant which are still in force (use extra paper if needed)

   ____________________

   ____________________

   (b) List policies you have sold to the applicant in the past five (5) years which are no longer in force (use extra paper if needed)

   ____________________

   ____________________

- 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 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) ____________________

| ____________________ | ____________________ |
|---|---|
| Agent's Name | ID Number |
| ____________________ | ____________________ |
| Signature of Agent | Date |

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.

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# 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 your existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross of Idaho Care Plus, Inc. Your new policy will provide a 30-day grace period within which you may decide, at no cost to you, 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 truthfully and completely 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 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.**

**Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.**

| ______________________________ | ______________________________ |
|---|---|
| Signature of Agent, Broker or Other Representative | Printed name and address of Insurer, Agent or Broker |
| ______________________________ | ______________ |
| Applicant's Signature | Date |

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Form No. 21-2493 (12-23)

## 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: 711), 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
Fax: 208-331-7493
Email: ***grievances&appeals@bcidaho.com***
TTY: 711

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: 711).

**Arabic** انتبه: إذا كنت تتحدث اللغة العربية ، فإن خدمات المساعدة اللغوية متاحة لك مجانًا اتصل على 1-800-627-1188 (للصم والبكم: 711).

**Bantu:** ICITONDERWA: Nimba uvuga Ikirundi, uzohabwa serivisi zo gufasha mu ndimi, ku buntu. Woterefona 1-800-627-1188 (TTY: 711).

**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：711）。

**Farsi** توجه: اگر به زبان فارسی صحبت می کنید، خدمات رایگان پشتیبانی زبان، در دسترس شما است. شماره تماس 1-800-627-1188 (TTY:711).

**French:** ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-627-1188 (ATS : 711).

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-627-1188 (TTY: 711).

**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:711）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: 711)번으로 전화해 주십시오.

**Nepali:** ध्यान दनुिहोस्: तपाइंले नेपाली बोल्नुहुन्छ भने तपाईको निम्ति भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छ । फोन गर्नुहोस् 1-800-627-1188 (टटिविाइ: 711) ।

**Romanian:** ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-627-1188 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-627-1188 (телетайп: 711).

**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: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-627-1188 (TTY: 711).

**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: 711.

**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: 711).