

Thank you for your interest in applying for the Premera BlueCross Medicare Supplement plan.

This application needs to be reviewed and signed by an Agent before they can be submitted to Premera BlueCross. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.888.632.5470 or 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

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

**Washington Medicare Supplement
Enrollment Application for
Plans A, F, High Deductible F and N**

P.O. Box 91120, MS 295
Seattle, WA 98111-9220
1-800-752-6663



You can become a Premera Blue Cross (Premera) Medicare Supplement member if you:

- Reside in Washington (excluding Clark County),
- Currently have both Medicare Part A and Part B, **and**
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

Don't send payment with this application.

Please PRINT, sign and date in blue or black ink. Applications that contain correction fluid or tape will not be accepted.

Important Notes

1. You do not need more than one Medicare Supplement policy. If you currently have a Medicare Supplement policy or Medicare Advantage policy (including a Medicare HMO or PPO), you cannot be enrolled unless you intend to replace your current coverage. Please complete a replacement form. If you purchase this contract, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. Medicaid is a public aid program for people with low income. It is not the same as Medicare.
3. If, after purchasing this plan, you become entitled to Medicaid, the benefits and subscription charges under your Medicare Supplement contract can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement plan (or, if that is no longer available, a substantially equivalent plan) will be re-instituted if requested within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the state Medicaid program, including benefits as a "Qualified Medicare Beneficiary" (QMB) or a "Specified Low-Income Medicare Beneficiary" (SLMB).
5. Except that you must provide information on diseases and disorders for which you have symptoms, please do not provide any information on any part of this application about genetic testing or genetic information, including any decision by an insurance company that is based on a genetic test or on genetic information.

D Paying for your Medicare Supplement Plan

Select one:

- Monthly paper bill by mail (move on to Section E).
- Automatic monthly withdrawal (AFT) from your bank account. (Complete all information below.) By choosing the AFT option, you save money. Please see the Outline of Coverage for rates.

Tip
 You can also pay by credit card after your first month's payment. Call us at 1-800-752-6663 for more information.

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account Holder's Name (print)		
Financial Institution or Bank Name		
Financial Institution/Bank City	State	ZIP
Bank Routing Number (see picture below)	Account Number (see picture below)	<input type="checkbox"/> Checking <input type="checkbox"/> Savings



Routing Number
 We can't set up automatic withdrawals with bank routing numbers that begin with a "5." If your routing number begins with a "5," call your bank to get the correct bank routing number.

Bank Routing Number Account Number

Additional Terms and Conditions:

- Funds are transferred on the 5th business day of each month to pay for that month's coverage. (For example, the deduction on January 5th pays for coverage in January.)
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure prompt cancellation, I must notify Premera no later than the 20th of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment on a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Account Holder Signature **X** _____ Today's Date / /


E Your Health Coverage Information

If you have 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 a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans. **Please answer all questions.**

To the best of your knowledge: (Please mark Yes or No below with an "X.")

- Y N 1. a. Did you turn age 65 in the last 6 months?
- Y N b. Did you enroll in Medicare Part B in the last 6 months?
- c. If Yes, what is the effective date? _____ / _____ / _____

You must include a copy of your Medicare card or fill in all boxes to the right. We cannot process your application without this information.

HEALTH  INSURANCE	
NAME OF BENEFICIARY	
MEDICARE CLAIM NUMBER	
<input type="text"/>	<input type="text"/>
IS ENTITLED TO	EFFECTIVE DATE
Part A Hospital Insurance	<input type="text"/> / <input type="text"/> / <input type="text"/>
Part B Medical Insurance	<input type="text"/> / <input type="text"/> / <input type="text"/>

- Y N 2. a. Are you covered for any medical assistance through the state Medicaid program?
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.
- Y N b. If Yes, will Medicaid pay your premiums for this Medicare Supplement plan?
- Y N c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium?
3. a. If you had coverage from any Medicare plan other than original Medicare within the last 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: _____ / _____ / _____
- Y N b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan?
- Y N c. Was this your first time in this type of Medicare plan?
- Y N d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?
- Y N 4. a. Do you have another Medicare Supplement policy in force?
- b. If so, with what company, and what plan do you have?
Company: _____ Plan: _____
- Y N c. If so, do you intend to replace your current Medicare Supplement policy with this plan?
- Y N 5. a. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan).
- b. If so, with what company and what kind of policy?
Company: _____ Policy: _____
- c. What are your dates of coverage under the other policy? **If you are still covered under the same policy, leave "End" blank.**
Start: _____ / _____ / _____ End: _____ / _____ / _____

E Your Health Coverage Information, continued

- Y N 6. a. Are you currently enrolled in a Medicare Supplement plan or an Individual medical plan offered by Premera Blue Cross or a Premera affiliate company?
- Y N b. If **Yes**, do you wish to terminate that coverage? If you answered Yes, complete the statement below:
I, _____ wish to terminate my _____ (plan name)
individual medical coverage effective ____/____/____ (the effective date of this Medicare Supplement plan).

F Do you need to complete "Section G: Your Health Conditions?"

If you can answer "Yes" to any of the questions listed below, you **DO NOT** need to complete Section G: Health Conditions. Please submit proof of prior coverage that supports "Yes" answers.

You are applying for coverage during your Open Enrollment period:

- Y N A. You are applying for coverage prior to or during the 6-month period beginning on the first day of the first month in which you are 65 years of age or older and enrolled for benefits under Medicare Part B.

You are applying for coverage within 63 days from the date your previous Medicare coverage ended and:

- Y N B. For Plans A, F and High Deductible F—your Medicare Advantage plan, Medicare Select plan or Program of All-Inclusive Care for the Elderly (PACE) terminated or no longer provided service in your area or you moved out of the service area.
- Y N C. For Plans A, F and High Deductible F—you were covered by an employer's group retiree plan that provided health benefits and the plan terminated or no longer provided benefits.
- Y N D. For Plans A, F and High Deductible F—your Medicare Supplement policy coverage terminated because the insurer became insolvent or bankrupt.
- Y N E. For Plans A, F and High Deductible F—your Medicare Supplement, Medicare Advantage or PACE insurer violated a material provision of the policy or the agent materially misrepresented the plan's provisions in marketing the plan.
- Y N F. You terminated your Premera Blue Cross Medicare Supplement plan and enrolled in a Medicare Advantage plan then voluntarily disenrolled from that plan within the first 12 months of enrolling. (You may enroll in the Premera Blue Cross Medicare Supplement plan you were previously enrolled in, however, if that Medicare Supplement plan is not available, you may enroll in Plans A, F or High Deductible F).
- Y N G. You joined a Medicare Advantage plan or a PACE program when you were first eligible for Medicare and within the first year of joining that plan, you decide to disenroll. (You may enroll in any of our Medicare Supplement plans).
- Y N H. You are transferring with no gap in coverage from a Medicare Supplement Plan A (issued on or after June 1, 2010) to Plan A.
- Y N I. You are transferring with no gap in coverage from a Medicare Supplement Plan B, C, F, High Deductible F, G, K, L, M or N (issued on or after June 1, 2010) or another more comprehensive plan to Plan F, High Deductible F or N.

Please submit proof of prior coverage that supports any "Yes" answers for the above questions.

G

Your Health Conditions

STOP!

You only need to complete this section if you answered "No" to all questions in Section F. If you answered "Yes" to any question in Section F please SKIP this section and move on to Section H.

1. Have you had any of the following conditions or received treatment during the past five years? Please mark (X) each condition "Yes" or "No" or the application will be returned.

Y N **1a.** Alcohol—Dependence or Abuse

Y N **1b.** Chemical/Drug—Dependence or Abuse

Y N **1c.** DWI/DUI Violations

Y N **2a.** Lupus (Not discoid)

Y N **2b.** Scleroderma

Y N **2c.** Mixed Connective Tissue

Y N **3a.** Anemia (Not iron deficiency or controlled pernicious anemia)

Y N **3b.** Bleeding Disorders (coagulation defect)

Y N **3c.** Hypercoagulation Disorders

Y N **3d.** Blood Disorder (Agranulocytosis, TCP, etc)

Y N **3e.** Leukemia

Y N **3f.** Aneurysm: brain, aortic

Y N **3g.** Impaired Circulation

Y N **3h.** High Cholesterol, Triglycerides

Y N **3i.** High Blood Pressure

Y N **3j.** High Blood Pressure: multiple medications and/or not controlled

Y N **3k.** Phlebitis (superficial)

Y N **3l.** Clots (DVT)/Thrombophlebitis

Y N **3m.** Raynauds (non-smoker)

Y N **3n.** Raynauds (smoker)

Y N **3o.** Peripheral Vascular Disease (PVD)

Y N **4a.** Congenital Disorder/Birth Defects (mild to moderate)

Y N **4b.** Congenital Disorder/Birth Defects (severe)

Y N **5a.** Nasal Malformation/Deviated Septum

Y N **5b.** Nasal Polyps

Y N **5c.** Recurrent Sinusitis

Y N **5d.** Tonsillitis

Y N **5e.** Crossed Eyes/Strabismus

Y N **5f.** Detached Retina

Y N **5g.** Macular: Degeneration (Verteporfin treatment)

Y N **5h.** Macular: Degeneration (No Verteporfin treatment)

Y N **5i.** Macular: Tear or Hole

Y N **5j.** Cataract(s)/Lens Implants

Y N **5k.** Glaucoma

Y N **6a.** Swallowing Problems

Y N **6b.** GERD/Acid Reflux/Hiatal Hernia

Y N **6c.** Stomach/Intestinal Ulcers

Y N **6d.** Chronic Abdominal Pain

Y N **6e.** Gallbladder Disorder/Gallstones

Y N **6f.** Diverticulitis

Y N **6g.** Hemorrhoids

Y N **6h.** Irritable Bowel Syndrome

Y N **6i.** Ulcerative Colitis

Y N **6j.** Crohn's Disease

Y N **6k.** Colitis

Y N **6l.** Hernia (Inguinal, Umbilical, Femoral, or Scrotal)

Y N **6m.** Polyps: Gastrointestinal, Rectal

Y N **6n.** Weight gain or loss of 10 lbs or more within 1 year

Y N **7a.** Diabetes

Y N **7b.** Elevated Blood Sugar

Y N **7c.** Goiter

Y N **7d.** Thyroid Nodule

Y N **7e.** Hyperthyroidism

Y N **7f.** Hypothyroidism

Y N **7g.** Other Adrenal/Pituitary Condition

Y N **7h.** Addison's Disease (adrenal insufficiency)

Y N **7i.** Cushing's Disease (hyperadrenocorticism)

Y N **8a.** Angina/Chest Pain

Y N **8b.** Heart Attack

Y N **8c.** Arterio-Atherosclerosis/Coronary Artery Disease

G

Your Health Conditions, continued

1. Have you had any of the following conditions or received treatment during the past five years?

Y N **8d.** Congestive Heart Failure (includes cardiomyopathy, cardiomegaly)

Y N **8e.** Heart Murmur

Y N **8f.** Arrhythmia: controlled

Y N **8g.** Arrhythmia: severe or not controlled

Y N **8h.** Pacemaker: post surgery/repair not anticipated, no complications

Y N **8i.** Pacemaker: pending surgery/repair or with complications

Y N **8j.** Heart Valve: Stenosis

Y N **8k.** Heart Valve: Regurgitation or Prolapse: minor

Y N **8l.** Heart Valve: Regurgitation or Prolapse: moderate/severe

Y N **8m.** Heart Valve: Infection

Y N **8n.** Heart Valve: replaced (transplant, artificial valve)

Y N **9a.** AIDS/AIDS Related Complex/HIV Positive

Y N **10a.** Bladder: Infections

Y N **10b.** Bladder: Incontinence (Not stress)/Retention

Y N **10c.** Kidney Infections (recovered from single episode)

Y N **10d.** Kidney Infections (not recovered or recurring)

Y N **10e.** Kidney Stones

Y N **10f.** Kidney Failure/Nephritis

Y N **11a.** Hepatitis A

Y N **11b.** Hepatitis B

Y N **11c.** Hepatitis C

Y N **11d.** Hepatitis Other

Y N **11e.** Cirrhosis/Liver Failure

Y N **12a.** Chronic Back or Neck Pain/Strain

Y N **12b.** Disc Problems: Bulging, Herniated, Slipped, Ruptured

Y N **12c.** Bone Spurs

Y N **12d.** Arthritis

Y N **12e.** Rheumatoid Arthritis

Y N **12f.** Osteoporosis/Bone Disorder

Y N **12g.** Fibromyalgia/Myositis

Y N **12h.** Chronic Fatigue Syndrome

Y N **12i.** Muscular Dystrophy

Y N **12j.** Polio Residuals

Y N **12k.** Bursitis

Y N **12l.** Gout

Y N **12m.** Carpal Tunnel Syndrome

Y N **12n.** Tendonitis/Repetitive Stress Injury

Y N **12o.** Joint Disorder

Y N **12p.** Joint Replacement: post revision/future surgery not anticipated

Y N **12q.** Joint Replacement: surgery/revision pending or completed recently

Y N **12r.** Joint Dislocation

Y N **12s.** Foot Disorder/Bunions/Hammertoe

Y N **12t.** Fractures

Y N **12u.** Fracture: pathological

Y N **12v.** Gait Abnormality

Y N **12w.** Loss of Limb(s)

Y N **12x.** Loss of Limb(s) due to disease

Y N **12y.** Chronic Pain/Decreased Range of Motion

Y N **12z.** Chronic Pain (Narcotic/Injury Pain Management)

Y N **13a.** Schizophrenia

Y N **13b.** Bipolar Mood

Y N **13c.** Psychosis

Y N **13d.** Depressive Disorder

Y N **13e.** Anxiety

Y N **13f.** Attempted Suicide

Y N **13g.** Anorexia

Y N **13h.** Bulimia

Y N **13i.** Attention Deficit Hyperactivity Disorder

Y N **14a.** Traumatic Brain Injury

Y N **14b.** Seizures

Y N **14c.** Cerebral Palsy

Y N **14d.** Stroke/TIA

Y N **14e.** Paralysis

Y N **14f.** Headaches (Recurrent or Migraine)

Y N **14g.** Multiple Sclerosis

G

Your Health Conditions, continued

1. Have you had any of the following conditions or received treatment during the past five years?

- Y N **14h.** Alzheimer's Disease
- Y N **14i.** Huntington's Chorea
- Y N **14j.** Amyotrophic Lateral Sclerosis
- Y N **14k.** Parkinson's Disease/Syndrome
- Y N **14l.** Other progressive neurological disorder
- Y N **14m.** Meningitis/Encephalitis (present, recurring)
- Y N **14n.** Meningitis/Encephalitis (resolved)
- Y N **14o.** Neurodevelopmental/Cognitive/Motor/
Speech Delay
- Y N **15a.** Transplant (excludes corneal)
- Y N **15b.** Critical Organ Cyst/Tumor (present)
- Y N **15c.** Critical Organ Cyst/Tumor (removed)
- Y N **15d.** Cancer: Local
- Y N **15e.** Cancer: Regional
- Y N **15f.** Cancer (Metastatic, Sarcoma,
Lymphoma, Myeloma, Hodgkins, Bone)
- Y N **15g.** Cancer Squamous/Basal Cell
- Y N **16a.** Breast Disorder/Fibrocystic Breast
Disease/Implant
- Y N **16b.** Abnormal Pap Smear (benign, reactive
cellular)
- Y N **16c.** Cervical Dysplasia
- Y N **16d.** Endometrium: Endometriosis/Hyperplasia
- Y N **16e.** Uterine Fibroids
- Y N **16f.** Uterine/ Cervix Polyps

- Y N **16g.** Ovarian: Cyst
- Y N **16h.** Testicular: Cyst/Torsion/Lump
- Y N **16i.** Enlarged Prostate
- Y N **16j.** Prostatitis
- Y N **16k.** Sexual Dysfunction or Impotence
- Y N **17a.** Allergies/Hay Fever (Not mild/seasonal)
- Y N **17b.** Asthma/Reactive Airway Disease
(non-status asthmaticus)
- Y N **17c.** Asthma: status asthmaticus
- Y N **17d.** Sleep apnea
- Y N **17e.** Chronic Bronchitis
- Y N **17f.** Pneumonia
- Y N **17g.** Tuberculosis
- Y N **17h.** Pulmonary Embolism
(Lung Clot) recovered
- Y N **17i.** Pulmonary Embolism (Lung Clot)
present or recurring
- Y N **17j.** Collapsed Lung
- Y N **17k.** Chronic Obstructive Lung Disease
- Y N **18a.** Genital Herpes
- Y N **18b.** Human Pap. Virus (HPV/Genital Warts)
- Y N **18c.** Other Sexually Transmitted Diseases
- Y N **19a.** Severe: Burns/Scars
- Y N **19b.** Skin Ulcers

G Your Health Conditions, continued

2. If you have answered "Yes" to ANY of the previous questions in this section or have experienced any other health issues in the past 5 years, complete this question.

Attach additional sheets if needed. You may wish to submit copies of relevant medical records to expedite the process (at your own expense).

Enter Condition Number:	<input type="text"/>	Condition Name	Dates of Condition (leave "End" date blank if ongoing) Start: ___/___/___ End: ___/___/___
Description of Treatment		Number of days in hospital, if applicable (inpatient stays only): <input type="text"/> Days (total)	
Do you still have this condition? <input type="checkbox"/> Yes, my condition persists <input type="checkbox"/> No, my condition is resolved. Please describe:		Do you anticipate future care? <input type="checkbox"/> Yes. <input type="checkbox"/> No, my condition is resolved. Please describe:	
Enter Condition Number:	<input type="text"/>	Condition Name	Dates of Condition (leave "End" date blank if ongoing) Start: ___/___/___ End: ___/___/___
Description of Treatment		Number of days in hospital, if applicable (inpatient stays only): <input type="text"/> Days (total)	
Do you still have this condition? <input type="checkbox"/> Yes, my condition persists <input type="checkbox"/> No, my condition is resolved. Please describe:		Do you anticipate future care? <input type="checkbox"/> Yes. <input type="checkbox"/> No, my condition is resolved. Please describe:	
Enter Condition Number:	<input type="text"/>	Condition Name	Dates of Condition (leave "End" date blank if ongoing) Start: ___/___/___ End: ___/___/___
Description of Treatment		Number of days in hospital, if applicable (inpatient stays only): <input type="text"/> Days (total)	
Do you still have this condition? <input type="checkbox"/> Yes, my condition persists <input type="checkbox"/> No, my condition is resolved. Please describe:		Do you anticipate future care? <input type="checkbox"/> Yes. <input type="checkbox"/> No, my condition is resolved. Please describe:	

G Your Health Conditions, continued

3. Have you taken medications within the past year?

- Yes. Please enter your medication information in the table provided below and also answer questions 4 and 5.
- No. Please move on to questions 4 and 5.

Medication name	Dose—how much medication you take every day	Duration	Diagnosis
	_____ mg (circle one) _____ ml _____ (times per day)		
	_____ mg (circle one) _____ ml _____ (times per day)		
	_____ mg (circle one) _____ ml _____ (times per day)		

4. Has any insurance company refused or restricted any insurance coverage for you?

- Yes. Explain in the area provided below.
- No.

5. Has any other future surgery, diagnostic testing or medical treatment been recommended or discussed for you?

- Yes. Explain in the area provided below.
- No.

H Conditions of Enrollment/Signatures

I, the undersigned, apply for enrollment with Premera Blue Cross (Premera). I represent that all statements and answers on this application are complete and true. I understand coverage is available to me due to: (1) my residing in Washington (excluding Clark County), (2) my enrollment in Medicare Parts A and B, and (3) my eligibility for Medicare due to age (65 or over). I understand and agree that coverage does not begin until Premera accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize Premera, at its option, to pay providers directly for services rendered. I also understand and agree that Premera may:

1. Accept this application; or
2. Deny this application, in which case any future subscription charges submitted will be refunded to, and accepted by me, unless I have requested enrollment in a different plan; or
3. Cancel my contract retroactively, if it is found that I have supplied false information, or any material information was omitted by or for me on this application.

I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated in its contract with me. If Premera discloses my personal information for any other reason, Premera will first remove any data that can be used to easily identify me or will get my signed authorization.

I authorize: any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator to disclose a copy of my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera or its representatives as allowed by law.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Yes **No** I understand that the Medicare Supplement contract will not pay benefits during the first three months after the effective date for any condition for which I have had treatment, medicine or diagnostic testing within the three months prior to my effective date. I understand that, under certain conditions, this limitation may be shortened or waived. The waiting period may be waived if I apply for this contract within 63 days of leaving other health-care coverage and I provide proof with this application. I have provided such proof.

Signature of Applicant X	Today's Date
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I Final Checklist

To help us process your application faster, please be sure that you have completed the following:

- You must be 65 or older and enrolled (or have proof of enrollment) in both Medicare Part A (hospital insurance) and Part B (medical insurance). You must also reside in Washington (excluding Clark County).
- Sign and date the application.
- Include a copy of the certificate of coverage from your prior insurer if needed.

J Producer Information (if applicable)

If this application is being submitted through a producer, he or she must complete the information below and a Notice of Replacement, if appropriate. If all information is not complete, this application will be returned.

Completion of this section by a producer is required.

1. List any other medical or health insurance policies sold to the applicant. _____

2. List policies sold which are still in force. _____

3. List policies sold in the past five years which are no longer in force. _____

4. Yes No: Did you see the applicant at the time this application was executed?
If the answer is "No," please explain: _____

Producer Name (Please Print) Dann Loewenthal	Premera Blue Cross Producer Number 5304B	Telephone Number 800.884.2343
Street Address PO Box 26540	City Eugene	State OR
		ZIP 97402
Producer Signature X		Date

FOR COMPANY USE ONLY		
Producer Number [][][][][]	Group Number [][][][][][]	Effective Date [][][][][][]

**Notice to Applicant
Regarding Replacement of
Medicare Supplement or
Medicare Advantage Coverage**

P.O. Box 327
Seattle, WA 98111-0327



APPLICANT LAST NAME	LAST NAME	SUBSCRIBER ID NUMBER
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SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE!

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a contract to be issued by Premera Blue Cross. Your new contract will provide thirty (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. 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 disability coverage you have that may duplicate this contract.

STATEMENT TO APPLICANT BY PRODUCER

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan.

The replacement contract is being purchased for the following reason(s) (check one):

- Additional benefits. Fewer benefits and lower premiums.
- No change in benefits, but lower premiums. Other (Please specify) _____
- Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment. _____
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.

- (1) If you have had your current Medicare supplement policy less than three months, health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered 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.
- (2) State law provides that your replacement contract may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. Premera Blue Cross will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new contract to the extent such time was spent (depleted) under the original policy.
- (3) 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 subscriber charges 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.

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

SIGNATURE OF PRODUCER	TYPED NAME AND ADDRESS OF PRODUCER
APPLICANT'S SIGNATURE	DATE