

# Washington Medicare Supplement Enrollment Application for Plans A, C, F and I

P.O. Box 91120, MS 295  
Seattle, WA 98111-9220



**THANK YOU FOR SELECTING PREMERA BLUE CROSS (PBC)**

**Please read the following statements to determine if one of these MedicarePlus Standardized Plans will meet your health-care coverage needs.**

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. If you are 65 or older, 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. If the Medicare supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the re-instituted plan will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
4. If you are eligible for and have enrolled in a Medicare supplement plan by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and subscription charges under your Medicare supplement plan can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement plan under these circumstances, and later lose your employer or union-based group health plan, 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 your employer or union-based group health plan. If the Medicare supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstated plan will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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).

**You must reside in Washington (excluding Clark County) and have both Medicare Part A and Part B to be eligible for these plans.**


**DO NOT SEND PAYMENT WITH THIS APPLICATION.**



c. If yes, what is the effective date? (Please fill in on the card below.)

All applicants must fill in the boxes on the card with the information printed on their Medicare cards or include a photocopy of their cards.

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	
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"/>

2. Are you covered for 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.  Yes  No
- a. Will Medicaid pay your subscription charges for this Medicare supplement coverage?  Yes  No
- b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium?  Yes  No
- (Important Note:** If you are receiving any kind of Medicaid assistance, you may not be eligible to apply for this plan.)
3. a. Are you applying for Plan A, C or F with no gap in coverage between a Medicare Advantage plan and the PBC Medicare supplement plan?★  Yes  No
- b. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a PACE plan, or a Medicare HMO or PPO) or a Medicare Select plan, fill in your start and end dates below. If you are still covered under this plan, leave “End” blank. Start:        /        /        End:        /        /
- c. If you are still covered under the Medicare plan in 3.b., do you intend to replace your current coverage with this new Medicare supplement plan? **(Important Note:** If you do not intend to replace your other Medicare plan, you are not eligible to apply for this plan. Your new Medicare supplement plan cannot take effect while a Medicare Advantage plan is still in force.)  Yes  No
- d. Are you applying for Plan A, C or F?  Yes  No
- e. If yes, did coverage under the Medicare plan in 3.b. end because:
- ☞ The plan was withdrawn in your area?★  Yes  No
  - ☞ You moved away from the plan’s service area?★  Yes  No
  - ☞ The carrier or producer materially misrepresented the plan or materially breached its terms?★  Yes  No
- (You may also check yes if your current coverage will end within 90 days after this application’s postmark date.)
- f. Was this your first time in this type of Medicare plan?  Yes  No
- g. Did you drop a Medicare supplement policy to enroll in the Medicare plan?  Yes  No
- If coverage under the Medicare plan in 3.b. ended for reasons other than those in 3.e., and you are applying within 63 days after you lost coverage, you may not need to complete the Health Statement. Please call us at 1-800-PLAN-ONE to find out if you qualify.

4. a. Do you have another Medicare supplement policy or certificate in force?  Yes  No
- b. If so, with which company and what plan do you have?  
 Company \_\_\_\_\_  
 Plan (A, B, C etc.) \_\_\_\_\_
- c. If so, do you intend to replace your current Medicare supplement policy with this coverage? (**Important Note:** If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this plan.)  Yes  No
- d. Are you transferring with no gap in coverage:
- From Plan A \_\_\_\_\_ To Plan A ★  Yes  No
  - From Plan I or J \_\_\_\_\_ To Plan C, F, or I ★  Yes  No
  - From Plan B, C, D, E, F, G, H, K or L  
 other more comprehensive plan \_\_\_\_\_ To Plan C or F ★  Yes  No
- e. Did your Medicare supplement coverage end because:
- The carrier went bankrupt? ★  Yes  No
  - The carrier or producer materially misrepresented the plan or materially breached its terms? ★  Yes  No
- (You may also check yes if your current coverage will end within 90 days after this application's postmark date.)
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.)  Yes  No
- a. If so, with which company and what kind of policy?  
 Company \_\_\_\_\_  
 Type of policy: Individual  Yes  No  
 Retiree group ★  Yes  No  
 Active employee group  Yes  No  
 Other \_\_\_\_\_
- b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)  
 Start: \_\_\_\_\_ End: \_\_\_\_\_

**SECTION C - HEALTH STATEMENT**

If required, this section must be completed by the applicant (see Section B).

**1. Please mark (X) each condition YES or NO or the application will be returned.** Indicate if you have had any of the following conditions or received treatment during the past five years.

- |                              |                             |  |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | a. Alcohol or drug abuse   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | b. Alzheimer's disease   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | c. Arthritis, back or spinal disorder, knee or hip problem   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | d. Asthma, chronic lung problem, emphysema, bronchitis, tuberculosis   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | e. Diabetes  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | f. Disorders of the stomach, intestines or liver   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | g. Cancer, tumors, leukemia  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | h. Disorders of the eyes or ears   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | i. Diseases related to the immune system [including AIDS or ARC (as diagnosed by the Western Blot Test or another test of equal or greater accuracy) or lupus] |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | j. Paralysis, stroke, neurological problem   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | k. High blood pressure, heart disease, vein or artery disease, angina, irregular heart function, heart attack  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | l. Nervous or emotional condition, depression  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | m. Urinary problem, disorders of kidneys, bladder or prostate  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | n. Do you have any other condition, injury, ailment or symptom not mentioned in items a - m? (If yes, list on next page.)                                      |

2. If any of the conditions are checked YES, please explain below. 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 relating to you or to any family member, including any decision by an insurance company that is based on genetic test or genetic information. Use additional paper if necessary. At your own expense you may submit with this application a physician's report on each "YES" health condition. Premera Blue Cross will promptly consider the additional information.

Item No.	Month/Year	Diagnosis, type of treatment	Name of physician

3. Please list any prescription drugs you are taking. Attach additional sheet if necessary.

Medication(s)	Diagnosis	Dosage

4. Have you been hospitalized within the last five years?     Yes     No  
 If yes, please list details below. Attach additional sheet if necessary.

Month/Year	Diagnosis, type of treatment	Name of hospital

5. Has future surgery, diagnostic testing or medical treatment been recommended?     Yes     No  
 If yes, please explain the type of treatment and the date it was recommended: \_\_\_\_\_  
 \_\_\_\_\_

6. If after health statement review, I am not eligible for MedicarePlus Plan A, C, F or I:  
 Enroll me in MedicarePlus Plan     A     C     F (if eligible)  
 Do not enroll me.

## SECTION D - AUTOMATIC FUNDS TRANSFER (AFT) AUTHORIZATION

I have selected the AFT payment option, and I hereby authorize Premera Blue Cross to initiate funds transfer from the bank or depository financial institution account shown below. I authorize my financial institution to honor these transfers. **Please indicate all dashes, spaces and zeros.**

Financial Institution or Bank Name:	
Account Holder's Name (print):	
City, State, ZIP:	Account Number:
Bank Routing Number:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings
<p><b>Terms and Conditions</b></p> <ul style="list-style-type: none"> <li>➤ Funds for each month of coverage are to be transferred on the fifth day of that month.</li> <li>➤ I understand that this agreement will remain in effect until Premera Blue Cross has received a written notice from me that it should be cancelled. To ensure prompt cancellation of my Automatic Funds Transfer, this notice must be submitted at least 20 days prior to my next scheduled payment. I have the right to stop payment of a specific transfer from my depository financial institution at least three days before the next scheduled payment date.</li> <li>➤ It may take as long as 45 days to set up an Automatic Funds Transfer. I understand that I may receive an invoice and have to make a payment myself to cover the initial months.</li> </ul> <p style="text-align: center;"><b>Please enclose a deposit slip or a voided check from the account TO BE DEDUCTED.</b></p> <p><b>X</b></p>	
Signature of Bank Account Holder	Date

## SECTION E - CHECK LIST

**To help us process your application faster, please take a moment to make sure that you have completed the following steps before you send your application.**

1. 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).
2. Fill in the areas on the sample Medicare card with the information on your own Medicare card or provide a copy of your Medicare card. We cannot process your application without your Medicare information.
3. You must answer all enrollment questions to the best of your knowledge.
4. Sign the application.
5. Include a copy of the certificate of coverage from your prior insurer if needed.

### Attention Producers!

- **Please read the last page of this application carefully and answer ALL questions.**
- **Complete producer information and signature are required.**

## SECTION F - EFFECTIVE DATE

Coverage starts on the first of the month after the application postmark date if all information is complete and accurate **and** you are enrolled in both Parts A and B of Medicare. To request a later effective date (no more than 90 days from postmark date), write that date here: \_\_\_\_\_/01/\_\_\_\_\_.

**If you are replacing a Medicare Advantage plan, you must request to delay the effective date until after the date your Medicare Advantage coverage ends. If you need help with this, please contact your producer.**

SECTION G - CONDITIONS OF ENROLLMENT

I, the undersigned, apply for enrollment with Premera Blue Cross (PBC). 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 PBC 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 MedicarePlus program. I authorize PBC, at its option, to pay providers directly for services rendered. I also understand and agree that PBC may:

- 1. Accept this application; or
2. Deny this application, in which case any subscription charges submitted will be refunded to, and accepted by me, unless I have requested enrollment in a different plan; or
3. Cancel or alter 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 PBC 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 PBC discloses my personal information for any other reason, PBC will first remove any data that can be used to easily identify me or will get my signed authorization.

I understand and agree that no producer may accept risk or alter the terms of the application or contract. Any such change can only be made over the signature of an officer of Premera Blue Cross.

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.

I understand that the MedicarePlus 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 of same with this application. I have provided such proof.

Yes No

I have received a copy of Medicare's Choosing a Medigap Policy guide.

Yes No

X

Signature of Applicant

Date

SECTION H - PRODUCER CERTIFICATION

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

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

