

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 it can be submitted to Premera BlueCross. You may email, fax or mail it in to CDA Insurance:

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

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)

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 are eligible to apply for a Premera Blue Cross (Premera) Medicare Supplement plan 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.

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.

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.

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 reinstated if requested within 90 days of losing Medicaid eligibility.

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).

Please print your answers clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions, incomplete answers, or the use of correction fluid or tape will result in the return of your application and may cause a delay in the effective date of your coverage.

A Your Information

Last Name		First Name		Middle Initial	Social Security Number (required)			
					<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Home Address (cannot be a P.O. Box)			City	County	State	ZIP		
					WA			
Mailing Address (if different from above)			City		State	ZIP		
Billing Address (if different from both above)			City		State	ZIP		
Phone Number ()				Alternate Phone Number ()				
Email Address								
Birthdate		Height		Weight / lbs.		Gender		
Month	Day	Year	Ft.	In.			<input type="checkbox"/> Male	<input type="checkbox"/> Female

B Your Plan Selection

Which Medicare Supplement Plan do you want to enroll in? Plan A Plan F Plan F: High Deductible Plan N

Yes No Did you receive a copy of the "Outline of Coverage?"

Yes No Did you receive a copy of Medicare's "Choosing a Medigap Policy" guide?

C When Would You Like Your Plan to Start (Effective Date)

You are eligible for coverage to start on the first of the month after the application postmark date if all information is completed and accurate **and** we approve your application. Please indicate the month you want your coverage to start.

I want this plan to begin on the 1st of _____ (enter month) (No more than 90 days after the application is signed.)

D Paying for your Medicare Supplement Plan

DO NOT send payment with this application.

Select one:

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



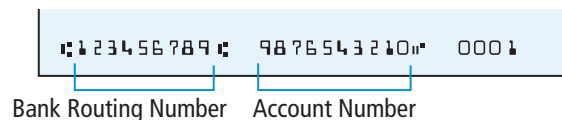
Tip

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		City	State ZIP
Bank Routing Number (see picture below)	Account Number (see picture below)	<input type="checkbox"/> Checking	<input type="checkbox"/> Savings

Include a photocopy of your voided check.



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 February 5th pays for coverage in February.)
- 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 Other 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 include a copy of the notice from your prior insurer with your application. **Please answer all questions.**

Please mark **Y (Yes)** or **N (No)** with an **"X."**

To the best of your knowledge:

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?
 _____ / _____ / _____

Medicare Claim Number:

- -

Hospital (Part A) Effective Date:

/ /

Medical (Part B) Effective Date:

/ /

Please attach a copy of your Medicare card or fill in your Medicare number and effective dates in the box above using the information from your Medicare card. We need all characters to enroll you.

Tell us about any help you receive from your state's Medicaid program (required):

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?

Tell us about your Medicare Supplement coverage (required):

Y **N** 3. a. Do you have another Medicare Supplement policy in force?

b. If so, with what company, and what plan do you have? Company: _____
 Plan: _____ Termination Date: _____ / _____ / _____

Y **N** c. If so, do you intend to replace your current Medicare Supplement policy with this plan?

Tell us about your Medicare Advantage coverage (required):

Y **N** 4. a. Have 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)? If so, 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?

Tell us about any other health insurance coverage:

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 other policy, leave "End" blank.**

Start: _____ / _____ / _____ End: _____ / _____ / _____

E Your Other Health Coverage Information, continued

Tell us about your health coverage offered by Premera, or a Premera affiliate company:

- 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 cancel 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?"

Check the box below that applies to you. If you check a box below, you **DO NOT** need to complete Section G: Your Health Conditions. Please submit evidence as described below to avoid delaying your application.

You are applying for coverage during your open enrollment period as described below.	Submit the following documents
<input type="checkbox"/> A. You are submitting this application prior to or during the 6-month period beginning on the first day of the first month in which you turned 65 years of age or older and enrolled for benefits under Medicare Part B.	Include your Medicare card information in Section E or a copy of your card.
You are applying for Plan A, F, or High Deductible F no later than 63 days from the date your previous coverage ended and...	Submit the following documents
<input type="checkbox"/> B. Your Medicare Advantage plan, Medicare Select plan or Program of All-Inclusive Care for the Elderly (PACE) terminated or is no longer providing service in your area or you moved out of the area.	If your previous carrier terminated or discontinued your plan: <ul style="list-style-type: none"> • Letter from prior carrier that contains reason for discontinuation/termination and the term date. If you moved out of your current carrier's service area: <ul style="list-style-type: none"> • Utility bill from previous address and termination letter from prior carrier showing termination date.
<input type="checkbox"/> C. You were covered by an employer's group plan that provided health benefits secondary to Medicare (such as COBRA, retiree, etc.) and the plan terminated or no longer provides benefits.	Submit a notice of termination or an explanation of benefits for a claim denied due to termination and <ul style="list-style-type: none"> • If you had a retiree plan, submit one of the following: <ul style="list-style-type: none"> - Termination letter showing it's a retiree plan; - Benefit booklet pages from your benefit booklet showing it's a retiree plan; or - Explanation of benefits showing Medicare paid primary. • If you had a COBRA plan, submit an election notice or COBRA bill (may be a coupon). • If you had a group plan secondary to Medicare, submit an explanation of benefits showing Medicare paid primary.

F Do you need to complete “Section G: Your Health Conditions?” continued

You are applying for Plan A, F, or High Deductible F no later than 63 days from the date your previous coverage ended and...	Submit the following documents
<input type="checkbox"/> D. Your Medicare Supplement policy terminated because the insurer became insolvent or bankrupt.	Letter from the carrier or Insurance Commissioner showing termination date.
<input type="checkbox"/> E. 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.	Letter from your prior carrier showing termination date.
<input type="checkbox"/> F. You terminated your Premera Medicare Supplement plan, enrolled in a Medicare Advantage plan, and then voluntarily disenrolled within the first 12 months of enrolling. (You may enroll in the Premera Medicare Supplement plan you were previously on. However, if that plan is not available, you may enroll in Plan A, F or High Deductible F.)	Letter from prior Medicare Advantage carrier showing effective and termination dates.
<input type="checkbox"/> G. You joined a Medicare Advantage or PACE plan when you were first eligible for Medicare and within the first 12 months of joining that plan, you disenrolled. (You may enroll in Plan A, F, High Deductible F or N.)	Letter from prior carrier showing termination date.
You are applying with <u>no gap in coverage</u> and...	Submit the following documents
<input type="checkbox"/> H. You are transferring with no gap in coverage from a Medicare Supplement Plan A to Plan A.	Letter from prior carrier showing Plan A coverage.
<input type="checkbox"/> 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 or another more comprehensive plan to Plan F, High Deductible F or N.	<p>If you are transferring from a Medicare Supplement plan, submit a letter from your prior carrier showing coverage.</p> <p>If you are transferring from a more comprehensive Group or Individual plan; a Medicare Advantage, Medicare Cost, Medicare Risk, healthcare prepayment, PACE plan:</p> <ul style="list-style-type: none"> • Letter from prior carrier showing termination date, and • Booklet summary of benefits or other documentation of prior plan’s benefits..

G Your Health Conditions

STOP!

You only need to complete this section if you did not check a box to any questions in Section F. Otherwise, move on to Section H.

Except when 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.

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

<input type="checkbox"/> Y <input type="checkbox"/> N 1a. Alcohol—Dependence or Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N 5d. Gallbladder Disorder/Gallstones
<input type="checkbox"/> Y <input type="checkbox"/> N 1b. Chemical/Drug—Dependence or Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N 5e. Diverticulitis
<input type="checkbox"/> Y <input type="checkbox"/> N 1c. DWI/DUI Violations	<input type="checkbox"/> Y <input type="checkbox"/> N 5f. Hemorrhoids
<input type="checkbox"/> Y <input type="checkbox"/> N 2a. Lupus	<input type="checkbox"/> Y <input type="checkbox"/> N 5g. Irritable Bowel Syndrome
<input type="checkbox"/> Y <input type="checkbox"/> N 2b. Scleroderma	<input type="checkbox"/> Y <input type="checkbox"/> N 5h. Ulcerative Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N 2c. Mixed Connective Tissue	<input type="checkbox"/> Y <input type="checkbox"/> N 5i. Crohn's Disease
<input type="checkbox"/> Y <input type="checkbox"/> N 3a. Anemia (Not iron deficiency or controlled pernicious anemia)	<input type="checkbox"/> Y <input type="checkbox"/> N 5j. Colitis
<input type="checkbox"/> Y <input type="checkbox"/> N 3b. Bleeding Disorders (coagulation defect)	<input type="checkbox"/> Y <input type="checkbox"/> N 5k. Hernia (Inguinal, Umbilical, Femoral, or Scrotal)
<input type="checkbox"/> Y <input type="checkbox"/> N 3c. Blood Disorder	<input type="checkbox"/> Y <input type="checkbox"/> N 5l. Polyps: Gastrointestinal, Rectal
<input type="checkbox"/> Y <input type="checkbox"/> N 3d. Leukemia	<input type="checkbox"/> Y <input type="checkbox"/> N 5m. Weight gain or loss of 10 lbs or more within 1 year
<input type="checkbox"/> Y <input type="checkbox"/> N 3e. Aneurysm: brain, aortic	<input type="checkbox"/> Y <input type="checkbox"/> N 6a. Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N 3f. Impaired Circulation	<input type="checkbox"/> Y <input type="checkbox"/> N 6b. Elevated Blood Sugar
<input type="checkbox"/> Y <input type="checkbox"/> N 3g. High Cholesterol, Triglycerides	<input type="checkbox"/> Y <input type="checkbox"/> N 6c. Goiter
<input type="checkbox"/> Y <input type="checkbox"/> N 3h. High Blood Pressure	<input type="checkbox"/> Y <input type="checkbox"/> N 6d. Thyroid Nodule
<input type="checkbox"/> Y <input type="checkbox"/> N 3i. Phlebitis	<input type="checkbox"/> Y <input type="checkbox"/> N 6e. Hyperthyroidism
<input type="checkbox"/> Y <input type="checkbox"/> N 3j. Clots (DVT)/Thrombophlebitis	<input type="checkbox"/> Y <input type="checkbox"/> N 6f. Hypothyroidism
<input type="checkbox"/> Y <input type="checkbox"/> N 3k. Raynauds (non-smoker)	<input type="checkbox"/> Y <input type="checkbox"/> N 6g. Adrenal/Pituitary Condition
<input type="checkbox"/> Y <input type="checkbox"/> N 3l. Raynauds (smoker)	<input type="checkbox"/> Y <input type="checkbox"/> N 7a. Angina/Chest Pain
<input type="checkbox"/> Y <input type="checkbox"/> N 3m. Peripheral Vascular Disease (PVD)	<input type="checkbox"/> Y <input type="checkbox"/> N 7b. Heart Attack
<input type="checkbox"/> Y <input type="checkbox"/> N 4a. Nasal Malformation/Deviated Septum	<input type="checkbox"/> Y <input type="checkbox"/> N 7c. Arterio-Atherosclerosis/Coronary Artery Disease
<input type="checkbox"/> Y <input type="checkbox"/> N 4b. Nasal Polyps	<input type="checkbox"/> Y <input type="checkbox"/> N 7d. Congestive Heart Failure (includes cardiomyopathy, cardiomegaly)
<input type="checkbox"/> Y <input type="checkbox"/> N 4c. Recurrent Sinusitis	<input type="checkbox"/> Y <input type="checkbox"/> N 7e. Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N 4d. Detached Retina	<input type="checkbox"/> Y <input type="checkbox"/> N 7f. Arrhythmia
<input type="checkbox"/> Y <input type="checkbox"/> N 4e. Macular: Degeneration	<input type="checkbox"/> Y <input type="checkbox"/> N 7g. Pacemaker
<input type="checkbox"/> Y <input type="checkbox"/> N 4f. Macular: Tear or Hole	<input type="checkbox"/> Y <input type="checkbox"/> N 7h. Heart Valve: Stenosis
<input type="checkbox"/> Y <input type="checkbox"/> N 4g. Cataract(s)/Lens Implants	<input type="checkbox"/> Y <input type="checkbox"/> N 7i. Heart Valve: Regurgitation or Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N 4h. Glaucoma	
<input type="checkbox"/> Y <input type="checkbox"/> N 5a. GERD/Acid Reflux/Hiatal Hernia	
<input type="checkbox"/> Y <input type="checkbox"/> N 5b. Stomach/Intestinal Ulcers	
<input type="checkbox"/> Y <input type="checkbox"/> N 5c. Chronic Abdominal Pain	

G

Your Health Conditions, continued

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

- Y N **7j.** Heart Valve: replaced (transplant, artificial valve)
- Y N **8a.** AIDS/AIDS Related Complex/HIV Positive
- Y N **9a.** Bladder: Infections
- Y N **9b.** Bladder: Incontinence (Not stress)/ Retention
- Y N **9c.** Kidney Infections
- Y N **9d.** Kidney Stones
- Y N **9e.** Kidney Failure/Nephritis
- Y N **10a.** Hepatitis A, B, C, D, E or G
- Y N **10b.** Cirrhosis/Liver Failure
- Y N **10c.** Other Liver Condition
- Y N **11a.** Chronic Back or Neck Pain/Strain
- Y N **11b.** Disc Problems: Bulging, Herniated, Slipped, Ruptured
- Y N **11c.** Bone Spurs
- Y N **11d.** Osteoarthritis
- Y N **11e.** Rheumatoid Arthritis
- Y N **11f.** Osteoporosis/Bone Disorder
- Y N **11g.** Fibromyalgia/Myositis
- Y N **11h.** Chronic Fatigue Syndrome
- Y N **11i.** Polio Residuals
- Y N **11j.** Bursitis
- Y N **11k.** Gout
- Y N **11l.** Carpal Tunnel Syndrome
- Y N **11m.** Tendonitis/Repetitive Stress Injury
- Y N **11n.** Joint Replacement
- Y N **11o.** Joint Dislocation
- Y N **11p.** Foot Disorder/Bunions/Hammertoe
- Y N **11q.** Fractures
- Y N **11r.** Loss of Limb(s)
- Y N **11s.** Chronic Pain
- Y N **12a.** Schizophrenia
- Y N **12b.** Bipolar Mood
- Y N **12c.** Depressive Disorder
- Y N **12d.** Attempted Suicide
- Y N **12e.** Eating Disorder/Anorexia, Bulimia

- Y N **13a.** Traumatic Brain Injury
- Y N **13b.** Seizures
- Y N **13c.** Cerebral Palsy
- Y N **13d.** Stroke/TIA
- Y N **13e.** Paralysis
- Y N **13f.** Headaches (Recurrent or Migraine)
- Y N **13g.** Multiple Sclerosis
- Y N **13h.** Alzheimer's Disease
- Y N **13i.** Amyotrophic Lateral Sclerosis
- Y N **13j.** Parkinson's Disease/Syndrome
- Y N **13k.** Other progressive neurological disorder
- Y N **13l.** Meningitis/Encephalitis
- Y N **14a.** Transplant (excludes corneal)
- Y N **14b.** Critical Organ Cyst/Tumor
- Y N **14c.** Cancer
- Y N **14d.** Cancer Squamous/Basal Cell
- Y N **15a.** Breast Disorder/Fibrocystic Breast Disease/Implant
- Y N **15b.** Abnormal Pap Smear (benign, reactive cellular)
- Y N **15c.** Ovarian: Cyst
- Y N **15d.** Testicular: Cyst/Torsion/Lump
- Y N **15e.** Enlarged Prostate
- Y N **15f.** Prostatitis
- Y N **16a.** Allergies/Hay Fever (Not mild/seasonal)
- Y N **16b.** Asthma/Reactive Airway Disease
- Y N **16c.** Sleep apnea
- Y N **16d.** Chronic Bronchitis
- Y N **16e.** Pneumonia
- Y N **16f.** Tuberculosis
- Y N **16g.** Pulmonary Embolism (Lung Clot)
- Y N **16h.** Collapsed Lung
- Y N **16i.** Chronic Obstructive Lung Disease
- Y N **17a.** Sexually Transmitted Diseases
- Y N **18a.** Severe: Burns/Scars
- Y N **18b.** 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 section. Attach additional sheets if needed.

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

Continue to the next page



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 subscription charges submitted will be refunded to, and accepted by me; or
3. Within the first two years of my coverage, void my contract (in other words, cancel my coverage back to its effective date, as if never existed at all) if I have made any intentionally false or misleading statements on this application or enrollment form that are material enough to affect my acceptability for coverage.

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 further understand that any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator may disclose 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.

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 healthcare coverage and I provide proof with this application.

If you answered yes to questions 3 or 4 in Section E, you must complete and sign the attached replacement notice.


Signature of Applicant X	Today's Date
---------------------------------	--------------

!!! IMPORTANT: Be sure to return the entire application. !!!

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).
- Include a photocopy of your voided check if you want to pay by Automatic Funds Transfer (see Section D).
- Include a copy of the proof required in Section F if needed.
- Sign and date the application.

Continue to the next page for the Replacement Notice. 

J Producer Information (if applicable)

Be sure to return this page to us even if you do not have a producer.

If this application is being submitted through a producer, he or she must complete the information below and the attached 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)	Premera Blue Cross Producer Number	Telephone Number
Street Address	City	State ZIP
Producer Signature	Date	

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

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



Applicant last name

First name

Subscriber ID number

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 issuer, producer or other representative

We have reviewed your current medical or health insurance coverage. To the best of our 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):

- Additional benefits
- No change in benefits, but lower premiums
- Disenrollment from a Medicare Advantage Plan.
- Fewer benefits and lower premiums
- Plan has outpatient prescription drug coverage and you are enrolling in Part D

Please explain reason for disenrollment: _____

Other (please specify): _____

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 or certificate 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 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 subscription 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 contract and are sure that you want to keep it. If you have any questions, please call us at 1-800-752-6663 or contact your producer.

Signature of producer or representative (signature not required for direct response sales) X	Printed name and address of producer or representative
Applicant's signature X	Date