



# INDIVIDUAL COVERAGE APPLICATION FORM

## A To apply for MedigapSecurity . . .

Please reference the enclosed MedigapSecurity Outline of Coverage for the monthly premium based on your plan.

Check the ONE plan for which you are enrolling:

- Plan A     
  Plan B     
  Plan C     
  High Deductible Plan F

Or, if you are within 6 months of your Medicare Part B effective date, you may also select from the following plans\*:

- Plan F     
  Plan N

\*Exceptions apply. Please see the enclosed insert. "Your Rights to Guaranteed Issue of Medicare Supplemental Policies".

Desired effective date: \_\_\_\_\_

**Please check desired billing cycle:**

- Monthly  
 Bi-monthly  
 Quarterly

LAST Name:	FIRST Name:	Middle Initial	S.S.#: / /
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Birth Date: □□-□□-□□□□	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Home Phone Number: □□□-□□□-□□□□
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Permanent Residence Street Address: \_\_\_\_\_

City:	State:	ZIP Code:
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**Mailing Address** (only if different from your Permanent Residence Address):

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: □□ ZIP Code: □□□□□□

**Emergency Contact:** \_\_\_\_\_

**Phone Number:** □□□-□□□-□□□□ **Relationship to You:** \_\_\_\_\_

E-mail Address: \_\_\_\_\_

If current subscriber, please provide Identification Number: \_\_\_\_\_

## B Please provide your Medicare insurance information

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card
- OR –
- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join MedigapSecurity.



Name: \_\_\_\_\_

Medicare Claim Number      Sex \_\_\_\_\_

□□□□□□□□      □□

Is Entitled To      Effective Date

**HOSPITAL (Part A)**      □□-□□-□□□□

**MEDICAL (Part B)**      □□-□□-□□□□

**White** – Enrollment Copy

**Pink** – Customer Copy

## Please answer the following questions

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be guaranteed acceptance in one 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 Yes or No below with an X.

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? .....  Yes  No
2. Did you enroll in Medicare Part B in the last 6 months? .....  Yes  No

If yes, what is the effective date?..... --  
MM DD YYYY

3. Are you covered for medical assistance through the state Medicaid program? .....  Yes  No

*NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.*

If yes, will Medicaid pay your premiums for this Medicare supplement policy? .....  Yes  No

Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? .....  Yes  No

4. Are you enrolled in PACE (Pennsylvania Pharmaceutical Assistance Contract for the Elderly)? ....  Yes  No

5. 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** --  
MM DD YYYY MM DD YYYY

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

Was this your first time in this type of Medicare plan? .....  Yes  No

Did you drop a Medicare supplement policy to enroll in the Medicare Plan? .....  Yes  No

6. Do you have another Medicare supplement policy in force? .....  Yes  No

If yes, with what company and what plan do you have? \_\_\_\_\_

If yes, do you intend to replace your current Medicare supplement policy with this policy? .....  Yes  No

7. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? .....  Yes  No

If yes, with what company and what kind of policy? \_\_\_\_\_

What are your dates of coverage under the policy? (If you are still covered under the other policy, leave "END" blank.)

**START** -- **END** --  
MM DD YYYY MM DD YYYY

8. **To all Producers:** Producers shall list other health insurance policies they have sold to the applicant.

Following policies are still in force: \_\_\_\_\_

Following policies are not in force: \_\_\_\_\_

\_\_\_\_\_  
Signature of Producer

**D** **IMPORTANT — please read carefully**

You do not need more than one 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 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 policy or, if the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstated if requested within 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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 reinstated if requested within 90 days of losing your employer or union-based group 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

Counseling services may be available in your state 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).

**Please read and sign below**

I hereby apply for the Policy coverage specified below. I understand that this application is subject to your acceptance and to the conditions and exclusions contained in the agreement. I agree to pay charges for these coverages as billed. I am covered by Medicare Part A and Part B.

I acknowledge and agree that any personally identifiable health information about me (“Protected Health Information”) is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Independence Blue Cross and/or Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Independence Blue Cross and/or Highmark’s Notice of Privacy Practices is available at [www.ibxmedicare.com](http://www.ibxmedicare.com).

I understand that the Independence Blue Cross/Highmark Blue Shield MedigapSecurity policy that I am applying for has a pre-existing condition provision. Under this provision, benefits related to any pre-existing condition will not be provided for six months after I enroll in MedigapSecurity. I also understand, however, that the pre-existing condition provision will not apply to these benefits if, when I enroll in MedigapSecurity, I have already satisfied a pre-existing condition provision for the benefits under another Medicare supplement policy or the pre-existing condition provision is waived because I am an “eligible person” as defined by federal and Pennsylvania laws and regulations.

If I was previously enrolled under another Blue Cross® and Blue Shield® policy or a Medicare supplement policy with another company with a pre-existing condition limitation, coverage under this policy for a pre-existing condition limitation will only be excluded to the extent of the time that I did not satisfy the pre-existing condition exclusion period under the previous policy and in no event shall such pre-existing condition exclusion exceed six (6) consecutive months from the effective date of my coverage under this policy.

“Pre-existing Condition” means a disease or physical condition for which medical advice or treatment has been received by me within one hundred eighty (180) days immediately prior to my initial effective date under this agreement or any endorsement made part of this policy.

I understand that I can find complete details of the program(s) in the Policy which I will receive after I return this Application Form.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this application and 2) documentation of this authority is available upon request by Independence Blue Cross and Highmark Blue Shield or by Medicare.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Benefits underwritten or administered by Independence Blue Cross and Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

**Your Signature:** \_\_\_\_\_

**Today’s Date:**   -   -

FOR OFFICE USE ONLY		
IDENT. No.		
GR NO	TR DT	REAS
BC EFF	PR ST	ORIG
BS EFF	TC	

If you are the authorized representative, you must provide the following information:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number:    -    -     Relationship to Applicant: \_\_\_\_\_

**1901 Market Street, Philadelphia PA 19103-1480**



*Not connected with or endorsed by the U.S. Government or the federal Medicare program.*