34329

MedigapSecurity

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

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."

Please check desired billing cycle:

☐ Monthly
☐ Bi-monthly
☐ Quarterly

Desired effective date: ☐☐-0 1-☐☐☐☐
MM DD YYYY

LAST Name: FIRST Name Middle Initial: S.S.#: ☐☐☐-☐☐-☐☐☐☐

Birth Date: ☐☐-☐☐-☐☐☐☐
M M D D Y Y Y Y

Sex: ☐ M ☐ F

Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

Permanent Residence Street Address:

City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Emergency Contact: _____

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Relationship to You:** _____

Email Address (optional): _____

By giving us your email address and providing your signature in the designated box, you are providing permission for us to contact you with information related to your health benefits, additional products, services and/or educational information related to your health care. Providing your email address is optional.

If current subscriber, please provide Identification Number: _____

White – Enrollment Copy **Pink** – Customer Copy

B Please provide your Medicare insurance information

Please take out your Medicare Card to complete this section.

- Please fill in these blank boxes so that 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.

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: _____

Medicare Claim Number ☐☐☐☐☐☐☐☐☐☐ Sex _____

Is Entitled To Effective Date

HOSPITAL (Part A) ☐☐-☐☐-☐☐☐☐

MEDICAL (Part B) ☐☐-☐☐-☐☐☐☐

C 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 ☐☐-☐☐-☐☐☐☐ (MM DD YYYY) **END** ☐☐-☐☐-☐☐☐☐ (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

C Please answer the following questions continued

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
   If currently enrolled in a Medicare Advantage plan, your Medigap Plan effective date should start upon the date your Medicare Advantage plan coverage will end.

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** ☐☐-☐☐-☐☐☐☐

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 reinstituted 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 reinstituted 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 reinstituted 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 reinstituted 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).

E 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.

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 that 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: _____

Independence Blue Cross Highmark Blue Shield

Independence Blue Cross and Highmark Blue Shield are independent licensees of the Blue Cross and Blue Shield Association.

1901 Market Street, Philadelphia, PA 19103-1480

MedigapSecurity is not connected with or endorsed by the U.S. government or the federal Medicare program.

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-877-393-6733. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-877-393-6733. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑问。如果您需要此翻译服务，请致电 1-877-393-6733。我们的中文工作人员很乐意帮助您。这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯服務。如需翻譯服務，請致電 1-877-393-6733。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-877-393-6733. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-877-393-6733. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-877-393-6733 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-877-393-6733. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-877-393-6733. 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы

воспользоваться услугами переводчика, позвоните нам по телефону 1-877-393-6733. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية 6733-393-877-1. لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على . سيقوم شخص ما بمساعدتك. هذه خدمة مجانية يتحدث العربية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-877-393-6733. पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-877-393-6733. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-877-393-6733. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-877-393-6733. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-877-393-6733. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-877-393-6733. にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

Pennsylvania Dutch:
Wann du enniche Questions hoscht weeich unser Health odder Drug Plan, kenne mer en Interpreter griege as Deitsch schwetze kann fer dich helfe fer nix. Fer en Interpreter griege, ruf uns aa an 1-877-393-6733. Ebber as Deitsch schwetze kann zellt dich helfe. Des koscht nix.

Discrimination is Against the Law

Independence

Independence complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Independence does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Independence provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact our Civil Rights Coordinator.

If you believe that Independence has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator:

- by writing:
  - Independence Blue Cross
    1901 Market Street
    Attn: Civil Rights Coordinator
    Philadelphia, PA
- by calling: 1-888-377-3933 (TTY/TDD: 711)
- by faxing: 215-761-0245
- by emailing: civilrightscoordinator@ibx.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights:

- electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
- by writing:
  - U.S. Department of Health and Human Services
    200 Independence Avenue SW
    Room 509F, HHH Building
    Washington, DC 20201
- by calling 1-800-368-1019, 1-800-537-7697 (TDD).
- Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Independence Blue Cross offers products through its subsidiaries Independence Hospital Indemnity Plan, Keystone Health Plan East and QCC Insurance Company, and with Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Independence Blue Cross offers Medicare Advantage plans with a Medicare contract. Enrollment in Independence Medicare Advantage plans depends on contract renewal.