HIGHMARK®

AGENT & OFFICE USE ONLY		
Date Received:	Group Number:	Effective Date:
Agent Number:	Agency Number:	

In which channel was this application received?

❑ Face to Face Consultation ❑ Medicare Solutions Seminar
❑ Highmark Direct Store ❑ Member Benefits Forum
❑ Pre-set Home Visit ❑ Other

APPLICATION FOR MEDICARE SUPPLEMENT PROGRAM MEDIGAP BLUE

1. ELIGIBILITY

If you are not eligible for Medicare Part A AND enrolled in Medicare Part B, you are not eligible to enroll in Medigap Blue. Do not complete this application. If you are eligible, please refer to the page with instructions for completing this application.

2. APPLICANT'S NAME, HOME ADDRESS AND APPLICANT'S MAILING ADDRESS (If different from your home address.)

First Name	Middle Initial (if applicable)	Last Name	Suffix	Sex ❑ Male ❑ Female
Home Address (No P.O. Boxes)	Apt# City	State Zip	County	
Mailing Address (P.O. Boxes allowed)	Apt# City	State Zip	Date of Birth / /	
Home Phone (with area code) ( )	Email Address (if applicable)			

3. COVERAGE PLANS

Check the one plan for which you are enrolling.

Please reference the enclosed Medigap Blue Outline of Coverage for the monthly premium based on your age and/or eligibility. If you have any questions or need assistance determining the correct premium, call 1-866-673-9109.

Check the ONE plan for which you are enrolling:

❑ Plan A
❑ Plan B
❑ Plan C
❑ Plan D
❑ Plan F
❑ High Deductible Plan F
❑ Plan G
❑ Plan N

Rates subject to change.
Enrollment subject to approval.

5. ADDITIONAL INFORMATION

If you 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 such 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.

To the best of your knowledge:

i. Did you turn age 65 in the last 6 months? ..... ❑ Yes ❑ No
ii. Did you enroll in Medicare Part B in the last 6 months? ..... ❑ Yes ❑ No
iii. If yes, what is the effective date? ____/____/____
iv. Are you covered for Medical Assistance through the state Medicaid program? .... ❑ Yes ❑ No
   A. **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.
   B. If yes,
      1. Will Medicaid pay your premiums for this Medicare supplement policy? ... ❑ Yes ❑ No
      2. Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ..... ❑ Yes ❑ No
v. If you had coverage from any Medicare plan other than the 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 ____/____/____
vi. 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

Select an Effective Date: 1st of _____ (specify month)

4. APPLICANT INFORMATION

Previous Group Number	❑ Male ❑ Female	Your Birthdate	Age	Medicare Claim Number	Medicare Effective Dates Hospital Part A	Medical Part B

Applicant's Social Security Number:

Please turn to next page

Mail to Highmark Blue Shield, P.O. Box 535049, Pittsburgh, PA 15253-9801

5. ADDITIONAL INFORMATION (continued)

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

viii. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ..... ❑ Yes ❑ No

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

A. If so, with what company and what plan do you have? _____

_____

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

x. 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 what company and what kind of policy? _____

_____

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

START ____/____/____ END ____/____/____

xi. **To all Producers:** Producers shall list in Section 12 other health insurance policies they have sold to the applicant.

xii. Do you have coverage under a Medicare Prescription Drug Program through Highmark or another company? ..... ❑ Yes ❑ No

If Highmark, please list the identification number on the front of your ID card: _____

6. BILLING INFORMATION

In the future bill me:

❑ Bimonthly (every 2 months) ❑ Quarterly (every 3 months) ❑ Monthly

If electronic funds transfer (EFT) is desired, please complete and return a separate EFT application which is included.

7. HEALTH SCREENING QUESTIONS

1. Are you within six months of turning age 65? ..... ❑ Yes ❑ No
2. Are you within 6 months of enrolling in Medicare Part B (Part B effective date on your Medicare card) ..... ❑ Yes ❑ No
3. Are you guaranteed acceptance into certain Medicare Supplement plans based on the conditions listed in the brochure "Important Information about Your Rights to Guaranteed Issue of Medicare Supplemental Policies" that you got with this application? ..... ❑ Yes ❑ No

If you answered "Yes" to any of questions 1, 2, or 3 above, skip to Section 8.

If you answered "No" to all of the questions 1, 2, and 3 above, continue to answer the following questions.

Prior to approving your Application for enrollment, Highmark reserves the right to review previous and current Applications for coverage as well as claims history.

When completing this application, please DO NOT INCLUDE any genetic information such as family medical history or any information related to genetic testing, genetic services, genetic counseling, or genetic diseases for which you believe that you may be at risk.

List all prescription drugs you are currently taking or have been medically advised to take: (If none, write in "None." If additional space is needed, attach a separate page and sign and date that page.)

MEDICATION	AMOUNT	CONDITION FOR WHICH PRESCRIBED	CURRENTLY TAKING
			❑ Yes ❑ No
			❑ Yes ❑ No
			❑ Yes ❑ No

Please fill out the following questions completely and accurately. If you are unsure how to respond, please consult your medical provider.

Were you enrolled in Medicare prior to age 65? ..... ❑ Yes ❑ No

Are you now or have you been advised in the next year to be:

admitted as an inpatient to a hospital? ..... ❑ Yes ❑ No

bedridden or confined to a wheelchair? ..... ❑ Yes ❑ No

enrolled in a hospice program? ..... ❑ Yes ❑ No

Have you been advised to have a joint replacement in the next year?
Have you received a joint replacement within the past six months?
❑ Yes ❑ No

Are you currently using or have you used supplementary oxygen in the last year? ..... ❑ Yes ❑ No

In the past two years, have you been medically diagnosed and/or advised by a member of the medical profession that you have Chronic Renal Disease (ESRD)? In the past two years, have you been medically diagnosed and/or advised by a member of the medical profession that you have kidney disease requiring dialysis, or are you currently receiving dialysis? ..... ❑ Yes ❑ No

In the past two years, have you been confined to a nursing facility for other than short term rehabilitation? ..... ❑ Yes ❑ No

In the past two years, have you received medical or surgical treatment, consulted with a licensed medical professional, taken medication or been advised by a licensed medical professional that you need medical or surgical treatment (including prescription drugs) for any of the following conditions?

a. Cancer (other than skin cancer), Leukemia or Lymphoma, Melanoma ..... ❑ Yes ❑ No

b. Heart, Coronary, or Carotid Artery Disease (not including high blood pressure), Heart attack, Aneurysm, Congestive Heart Failure or any other type of Heart Failure, Enlarged Heart, Stroke, Transient Ischemic Attacks (TIA), Hemophilia ..... ❑ Yes ❑ No

c. Bone marrow or other organ transplant ..... ❑ Yes ❑ No

d. Amyotrophic Lateral Sclerosis (ALS), Alzheimer's Disease or Dementia, Multiple Sclerosis (MS), Parkinson's Disease, Systemic Lupus Erythematosus (SLE) ..... ❑ Yes ❑ No

e. Acquired Immune Deficiency Disorder (AIDS), AIDS Related Complex (ARC), or tested positive for exposure to the Human Immunodeficiency Virus (HIV) infection? ..... ❑ Yes ❑ No

Have you smoked cigarettes or used any tobacco product within the past two years? ..... ❑ Yes ❑ No

Within the past two years, have you been diagnosed, received treatment (including prescription drugs), or had any of the following conditions?

a. Heart Rhythm Disorders ..... ❑ Yes ❑ No
b. Diabetes ..... ❑ Yes ❑ No
c. Cirrhosis of the Liver ..... ❑ Yes ❑ No
d. Macular Degeneration ..... ❑ Yes ❑ No

Lung/Respiratory Conditions

a. Chronic Obstructive Pulmonary Disease (COPD) .. ❑ Yes ❑ No
b. Emphysema ..... ❑ Yes ❑ No

Gastrointestinal Conditions

a. Chronic Pancreatitis. ..... ❑ Yes ❑ No
b. Esophageal Varices ..... ❑ Yes ❑ No
c. Ulcerative Colitis ..... ❑ Yes ❑ No

Musculoskeletal Conditions

a. Amputation due to disease ..... ❑ Yes ❑ No
b. Rheumatoid Arthritis ..... ❑ Yes ❑ No
c. Spinal Stenosis ..... ❑ Yes ❑ No
d. Degenerative Disc or Herniated Disc ..... ❑ Yes ❑ No
e. Osteoporosis ..... ❑ Yes ❑ No

Substance Abuse

a. Alcohol Abuse or Alcoholism ..... ❑ Yes ❑ No
b. Drug Abuse or use of illegal drugs ..... ❑ Yes ❑ No

Brain or Spinal Cord Conditions

a. Paraplegia, Quadriplegia, or Hemiplegia ..... ❑ Yes ❑ No

Psychological/Mental Conditions

a. Bipolar or Manic Depressive ..... ❑ Yes ❑ No
b. Schizophrenia ..... ❑ Yes ❑ No

Have you been hospitalized or had inpatient surgery within the past 5 yrs? ❑ Yes ❑ No

Have you ever been covered by Worker's Compensation, Disability or Subrogation for any of the conditions listed in the health screening questions? ..... ❑ Yes ❑ No

Height: _____ Weight: _____

8. APPLICATION STATEMENTS FOR MEDICARE SUPPLEMENT PROGRAM

1. You **do not need** more than one Medicare supplement policy.

2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

4. 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.

5. 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.

6. 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).

IMPORTANT: For the purposes of the sections that follow below, **"Creditable Health Care Coverage" includes, but is not limited to,** any Highmark Blue Shield group or individual health care program; another insurance company's individual, group, or Medicare Supplement program; certain Medicare health plans, for example, a Medicare health care maintenance organization (HMO) or preferred provider organization (PPO); a Program of All-Inclusive Care for the Elderly; or other government health plans such as Medicare, Medicaid, a state risk pool or FEHBP.

If you are currently enrolled in Creditable Health Care Coverage and your new Medigap Blue coverage will replace this Creditable Health Care Coverage without interruption - you are eligible for all Medigap Blue plan benefits as soon as your new coverage becomes effective. There is no waiting period for any pre-existing conditions you may have.

If you were previously, but are not currently, enrolled in some form of Creditable Health Care Coverage, you may be eligible for a waiver or reduction of your pre-existing condition exclusion if you satisfy **all** of the following requirements:

- Your prior Creditable Health Care Coverage was for a period of at least six (6) consecutive months; **and**
- You submit your completed application for Medigap Blue coverage to Highmark Blue Shield within sixty-three (63) days from the date that your most recent prior Creditable Health Care Coverage ended (or in certain instances, the date on which you were notified that your coverage will end); and
- You attach a copy of your "Certificate of Prior Creditable Coverage" to your application for Medigap Blue coverage or provide other proof of your Creditable Health Care Coverage prior coverage.

If you were not enrolled in any type of Creditable Health Care Coverage within the last sixty-three (63) day period prior to your application for Medigap Blue coverage, the following pre-existing exclusion clause will apply:

These Highmark Blue Shield Medigap Blue plans will not provide benefits during the first six (6) months of your coverage for any disease or physical condition for which you received treatment or advice from a physician during the six (6) month period before your new coverage became effective.

Notice: 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.

The accuracy and validity of the information that you provide in the Application, including your responses to the health questionnaire, is subject to review by the Plan. The Plan reserves the right to take appropriate action in the event the information is not true or accurate.

The Plan shall terminate the Agreement if the Subscriber obtained or attempted to obtain benefits or payment for benefits as a result of a material misrepresentation. If benefits were provided due to a material misrepresentation, the Subscriber agrees to reimburse the Plan for such benefits.

I understand and agree that the terms and conditions of my coverage will be controlled by the written agreement with Highmark Blue Cross Blue Shield and that they may adopt reasonable policies, procedures, rules and interpretations to administer the program. I recognize that my coverage will only apply to services or supplies that are provided on or after the effective date of my coverage. To the best of my knowledge, the information provided on this application is true and correct.

I acknowledge and agree that certain personally identifiable information about me (collectively, "Personal Information") is subject to various statutory privacy standards, including, but not limited to, state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, Highmark may use and disclose Personal Information as permitted or required by law, and to facilitate payment, treatment and health care operations as described in its Notice of Privacy Practices ("NPP"). I understand that a copy of Highmark's current NPP is available on Highmark's Web site, or from the Highmark Privacy Department.

I hereby apply for coverage under the Highmark Blue Shield Medigap Blue Agreement. I understand this application is subject to approval by Highmark Blue Shield and the provisions of the Agreement.

I further understand that any approval of this application by Highmark Blue Shield is conditioned upon my being enrolled in Parts A and B of Medicare. If for any reason I am not enrolled in Medicare Part A or B, Highmark Blue Shield has the right to deny my application for Medigap Blue. If for any reason I become ineligible for Medicare A and B at some future date, I agree to notify Highmark Blue Shield immediately.

I understand that when I purchase this coverage, any other direct pay Highmark Blue Shield coverage I may have in effect will be cancelled as of the effective date of the Medigap Blue coverage.

I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish Highmark Blue Shield medical or other information acquired by it under the Title VII program (Medicare) to the extent necessary to process any claim under the Highmark Blue Shield Medigap Blue Agreement in effect with Highmark Blue Shield.

I understand the insurance producer cannot approve coverage. This Application does not guarantee that coverage will be provided. I further understand coverage, if provided, will not take effect until issued by Highmark and that the actual subscription rate will not be determined until coverage is issued. I understand the person discussing Medigap Blue plan options with me is either employed by or contracted with Highmark and may be entitled to receive compensation based on my enrollment in a plan.

To the best of my knowledge and belief, the information provided on this application is true and correct.

9. SIGNATURE

I hereby acknowlege and agree that I have received an Outline of Medicare Supplement Coverage and the Guide to Health Insurance for People with Medicare. My signature below verifies that I have read, understand and agree to all items contained in Section 8 ("Application Statements for Medicare Supplement Program") of this form:

Phone #: ( )

Signature Date

10. EMERGENCY CONTACT

Phone #: ( )

Print Name

11. POWER OF ATTORNEY

Signature Date

12. THIS SECTION TO BE COMPLETED BY INSURANCE BROKER OR AGENT ONLY.

A. List any other health insurance policies you have sold to this applicant which are still in force: _____

_____

B. List any other health insurance policies you have sold to this applicant in the past five years which are no longer in force:

_____

Signature of Agent or Broker _____ Date _____

Print Name and I.D. Number _____

Agency Name and Number _____

Phone #: ( ) _____

FOR OFFICE USE:

_____

_____

_____

_____

INSTRUCTIONS FOR MAILING IN APPLICATION

Please review this checklist before you mail your application:

- ❑ Have you completed all sections of the application form?
- ❑ Are your name and address written correctly on the application form?
- ❑ Have you attached your Certificate of Prior Creditable Coverage or your previous plan's letter of termination? (if applicable)
- ❑ Have you signed and dated your application?
- ❑ Have you attached the applicant's Power of Attorney or documentation of Legal Guardianship? (if applicable)

Return your completed application to us.

Use the envelope provided or mail to:

Highmark Blue Shield
P.O. Box 535049
Pittsburgh, PA 15253-9801

HIGHMARK.
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

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

- 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)
- Provides 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 the Civil Rights Coordinator.

If you believe that the Plan 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: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the 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, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930 。

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-844-679-6930.

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ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

Geb Acht: Wann du Deitsch schwetzscht, kannscht du en Dolmetscher griege, un iss die Hilf Koschdefrei. Kannscht du 1-844-679-6930 uffrufe.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930 .

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-844-679-6930.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-844-679-6930 નંબર પર ફોન કરો .

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

ប្រការចងចាំ៖ បើលោកអ្នកនិយាយ ភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដែលអាចផ្តល់ជូនលោកអ្នក ដោយឥតគិតថ្លៃ។ ការហៅ 1-844-679-6930 ។

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930 .

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930. موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-844-679-6930.