SENIOR ENROLLMENT APPLICATION **For Seniors Age 65 to 75 with Medicare Parts A and B**

Please complete entire application.

Application for Blue Cross Senior Classic F Plan, a Medicare Select Plan to Supplement Medicare, with the AdvantageCare℠ Rider

Section 1 – Applicant Information

This complete original application will be returned to you, for your records, along with your certificate, when you are enrolled.

Please copy the information from your Medicare card here

NAME OF BENEFICIARY ____________________

CLAIM NUMBER ____________ SEX ______

IS ENTITLED TO	EFFECTIVE DATE
HOSPITAL INSURANCE	
MEDICAL INSURANCE	

Requested effective date, or end date of prior Medicare supplement, if replacing

__________/__________/__________

Name (as it appears on your Medicare card)

Social Security Number

Home Address, Apt. No., Suite No.

City	County	State	Zip

Billing Address (if different from home address)

City	County	State	Zip

Care of/Attention	Home Telephone Number	E-mail Address	Date of Birth
	( )		

If transferring from another Blue Cross Group/Individual or Blue Cross/Blue Shield out-of-state plan, indicate ⇨	Group Number	State	Certificate Number

When you provide a check as payment, you authorize us either to use information from your check to make a one-time electronic fund transfer (EFT) from your account or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment, and you will not receive your check back from your financial institution.

Section 2 – Billing Information

Blue Cross Use Only	Broker No.	Contract No.	H/S ❑ Yes ❑ No	Amount Received $
Group No.	Certificate No.	Effective Date	X Re. Cert. No.	

If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling toll-free 1-800-333-3883.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

Insert check face up. Please submit one month's premium. Check must be made payable to Blue Cross.

Section 3 – Health History

You must already be enrolled in Medicare Parts A and B to apply for this plan. Applicant must complete sections 3 and 4. You must qualify for the Blue Cross Classic F plan to be considered for the rider. If the answer to any of the following questions is "yes" you are not eligible for coverage. However, we will not deny coverage to any individual who is subject ot an d applies for coverage during any open enrollment period, or to any individual who qualifies for guaranteed issue coverage. If you are 65 or older and applying within six (6) months of your initial enrollment in Medicare Part B you will be guaranteed issue for the Classic F Plan. Guaranteed issue does not apply to the AdvantageCare Rider.

	Yes	No
A. Are you currently confined, or has confinement been recommended, to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair?	☐	☐
B. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement or surgery for the heart, arteries or intestines which has not yet been done?	☐	☐
C. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for 2 weeks? (Total all confinements)	☐	☐
D. Within the past 2 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for internal cancer, leukemia, Hodgkin's disease, coronary artery disease, heart attack, nephritis, kidney failure, stroke or brain disorder?	☐	☐
E. Within the past 5 years, have you ever experienced, been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for: AIDS/ARC, Alzheimer's disease, senility, dementia, Parkinson's disease, Multiple Sclerosis, neuromuscular disorders, congestive heart failure, heart valve replacement, open heart surgery or angioplasty, organ or tissue transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight?	☐	☐

Section 4 – Medical Information

Name of Primary Care Physician ______________________ Telephone (_____) ______________

Address____

List all prescriptions currently prescribed for your use: (If none, write "none") ______________________

____

List name, address and telephone number of prescribing physician if different from above:

____

____

	Yes	No
Do you now, or have you during the past five years, used any tobacco products including cigarettes, pipe, cigars or chewing tobacco?	☐	☐

Indicate your current: height _________ weight _________(lbs)

Section 4 – Medical Information (continued)

	Yes	No
R1. Have you ever experienced, been told you had, consulted for, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for any of the following conditions?	☐	☐
A. Neurological Diseases: amyotrophic lateral sclerosis, myasthenia gravis, muscular dystrophy, progressive memory loss/senility or dementia, and other neurological diseases, such as peripheral neuropathy and post polio syndrome malignant or benign tumor, stroke, or transient ischemia attacks (TIAs).	☐	☐
B. Diabetes: isulin dependent or with complications such as blindness, visual loss, nerve or cardiovascular complications, neuropathy, or kidney problems.	☐	☐
C. HIV Disorders: including AIDS, AIDS related disorders and HIV positive blood tests.	☐	☐
D. Mental Health Disorders: such as manic-depression, schizophrenia or other severe mental health behavior disorders and eating disorders.	☐	☐
E. Depression.	☐	☐
F. Cardiovascular Disorders: including arteriosclerosis (hardening of the arteries), congenital heart disease, and valvular heart disease.	☐	☐
G. Hypertension.	☐	☐
H. Chronic Infectious Diseases: such as osteomyelitis, phyelonephitis.	☐	☐
I. Disorders of the Liver & Gastrointestinal System: such as colitis, regional enteritis, pancreatic, hepatitis, liver failure and esophageal varices.	☐	☐
J. Kidney Disease: such as chronic renal failure, dialysis, chronic nephritis and polycystic kidney disorder.	☐	☐
K. Transplantation: including any organ (except cornea) or bone marrow.	☐	☐
L. Cancer Malignant Diseases (except basal cell and squamous cell skin cancers): such as leukemia, Hodgkin's disease, other lymphatic cancers, melanoma, liver, prostate cancer, colon cancer, or cancer of other organs.	☐	☐
M. Diseases of the Lung: such as COPD (chronic obstruction pulmonary disease), emphysema.	☐	☐
N. Asthma.	☐	☐
O. Auto Immune Disorders: such as lupus erytheuatosis (lupus), rheumatoid arthritis, Raynaud's disease, sarcoidosis, scleroderma.	☐	☐
P. Joint Replacement.	☐	☐
Q. Osteoporosis with Fractures.	☐	☐

Section 4 – Medical Information (continued)

R2. Are you currently receiving benefits under a disability income plan?

R3. Do you use any of the following medical appliances: grab bar, brace, catheter, cane, walker, or crutches?

R4. Do you need or receive help from any other person to perform the activities below due to health or physical difficulty?

Yes	No	Activity	Yes	No	Activity
☐	☐	Bathing	☐	☐	Toileting
☐	☐	Doing household chores (dishwashing, sweeping, etc.)	☐	☐	Moving from place to place in your home
☐	☐	Dressing	☐	☐	Meal Preparation
☐	☐	Eating	☐	☐	Shopping
☐	☐	Getting in or out of bed or chairs	☐	☐	Taking medications
☐	☐	Walking			

R5. In the past 5 years, for other than routine checkups, have you consulted for, sought treatment, had treatment recommended, received treatment (including drug therapy) or been hospitalized for any other illness or injury or had any medical or surgical treatment other than listed above? Yes ☐ No ☐

If "Yes," please list the name, address, and telephone number of the physician and condition, name and dosage of prescription medication(s):

Physician name, address, telephone number: ______________________________

Condition/name and dosage of prescription medication(s): ______________________________

Physician name, address, telephone number: ______________________________

Condition/name and dosage of prescription medication(s): ______________________________

If **one or more** of the answers to any of questions R4-R5 is "Yes," please attach explanation for review and consideration by the underwriter.

If applying for, but not accepted for the AdvantageCare Rider, if I qualify, I would like to be enrolled in: Blue Cross Senior Classic F (without the Rider) Yes ☐ No ☐

Section 5 – General 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:

Question	Yes	No
A. Did you turn age 65 in the last 6 months?	☐	☐
B. Did you enroll in Medicare Part B in the last 6 months?	☐	☐
C. If yes, what is the effective date? ________/________/________		
D. Are you covered for medical assistance through California's Medi-Cal program? NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.	☐	☐
If yes,		
i. Will Medi-Cal pay your premiums for this Medicare supplement policy?	☐	☐
ii. Do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?	☐	☐
E. If you had coverage from any Medicare plan other than original Medicare within the past 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 _______/_______/_______		
i. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	☐	☐
ii. Was this your first time in this type of Medicare plan?	☐	☐
iii. Did you drop a Medicare supplement policy to enroll in this Medicare plan?	☐	☐
F. Do you have another Medicare supplement policy in force?	☐	☐
i. If so, with what company, and what plan do you have? ____________________________		
ii. If so, do you intend to replace your current Medicare supplement policy with this policy?	☐	☐
G. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)	☐	☐
i. If so, with what company and what kind of policy? ________________________________		
ii. What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank. START _______/_______/_______ END _______/_______/_______		

Please be aware that if you currently enrolled in a Medicare Risk HMO plan, including Blue Cross Senior Secure℠, it is your responsibility to terminate your coverage prior to enrollment becoming effective with Blue Cross. Any unpaid claims resulting from failure to disenroll from your HMO plan will be your responsibility.

Section 6 – Conditions of Application

Please read the following carefully.

A. I agree to pay an application fee equal to the subscription charges required for the program requested on this application, that this payment will be returned to me if my application is rejected or will be applied to the subscription charges if my application is accepted.

B. Blue Cross has the right to reject my application. If Blue Cross rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if Blue Cross rejects my application, under no circumstances will any Blue Cross benefits be payable. ***Cashing of my check by Blue Cross does not constitute approval of my application.***

C. If my application is accepted, this application will become part of the agreement between Blue Cross and myself. If this application is accepted, I further agree to be bound by the arbitration agreement set forth in the application and I waive my right to court trial by judge or jury in the event of any dispute arising under this policy.

D. Blue Cross may request additional information, which may delay processing of this application. If the health care provider bills for this information, Blue Cross will pay up to $25 and I understand that I will be responsible for any difference.

E. The selling agent has no authority to promise me coverage or to modify Blue Cross underwriting policy or terms of any Blue Cross coverage.

F. I alone am responsible for reading and accurately completing this application. I understand that coverage under the contract will be voided only in the event that I fail to accurately respond to questions regarding my past or present health condition. I understand that I am not eligible for any benefits if any information requested on this application, even information about my Medicare coverage, is false, incomplete or omitted and that Blue Cross may void all coverage from the original effective date of the policy for misstatements or omissions.

G. California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

Notice to Applicant.

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 Medi-Cal or Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing the policy, you become eligible for Medi-Cal or Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, 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 Medi-Cal or 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 the 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 after 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 the 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 Medi-Cal or Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counceling services may be obtained from the California Department of Aging.

Section 7 – Authorization & Agreements

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome), or A.R.C. (AIDS-related complex), but not including psycho therapy notes.

Entities or Persons Authorized to Use or Disclose: U.S. Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional.

Entities or Persons Authorized to Receive: Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker, for the purpose(s) described below.

Purpose of this Authorization: By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Effect of Declining: If you decide not to sign this authorization, we may decline to enroll you in our health plan. This PHI used or disclosed may be subject to re-disclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon termination of any Blue Cross coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

Blue Cross of California
PO. Box 9063, Oxnard, CA 93031-9063
Telephone 1-800-333-3883, Fax 1-805-375-0361

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization, and I understand that, by signing this authorization, I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

	X	
Print Applicant's Name	**Applicant's Signature**	**Date**

Name of the other person or persons authorized to receive my PHI:

Name of other person authorized to use or disclose my PHI	**Relationship to Applicant**

X	
Applicant's Signature	**Date**

Section 7 – Authorization & Agreements (continued)

A photocopy of this authorization is as valid as the original, and I and my Blue Cross agent or broker are entitled to receive a copy of this form. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

- I have personally read and completed this application. I understand and agree to the Replacement Notification, the Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare", the Provider Directory, the Medicare Select Disclosures, the Medicare Select Review and Grievance Procedures and "Outline of Medicare Select Coverage and Premium Information" as required by California Health and Safety Code. I understand that receipt of money with this application does not create Blue Cross coverage. Coverage will come into effect only if this application is approved by Blue Cross of California.
- I, the applicant, acknowledge that I have read and understand this Application in its entirety.

X	
Applicant's Signature	**Date of Signature**

Section 8 – Binding Arbitration

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to, this Agreement, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court. The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, state law governing agreements to arbitrate shall apply. The Member and Blue Cross agree to be bound by these arbitration provisions and acknowledge that they are giving up their right to trial by court or jury.

California Health & Safety Code section 1363.1 requires that any arbitration agreement include the following notice: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

(continued on next page)

Section 8 – Binding Arbitration (continued)

The Member and Blue Cross agree to give up the right to participate in class arbitrations against each other. Even if applicable law permits class actions or class arbitrations, the Member waives any right to pursue, on a class basis, any such controversy or claim against Blue Cross and Blue Cross waives any right to pursue, on a class basis, any such controversy or claim against the Member. The arbitration findings will be final and binding except to the extent that state or federal law provides for the judicial review of arbitration proceedings. The arbitration is initiated by the Member making written demand on Blue Cross. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS"), according to its applicable Rules and Procedures. If for any reason JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by agreement of the Member and Blue Cross, or by order of the court, if the Member and Blue Cross cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to whom the parties have agreed, in which cases, Blue Cross will assume all or a portion of the costs of the arbitration. Please send all Binding Arbitration demands in writing to:

Blue Cross of California
P.O. Box 9063, Oxnard, CA 93031-9063

X

Applicant's Signature | **Date of Signature**

Optional Monthly Checking Account Deduction Authorization for Seniors.

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of BLUE CROSS OF CALIFORNIA provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize Blue Cross of California to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my Blue Cross of California dues. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID".

Subscriber		Social Security Number	
Group Number		Bank Name	
X	Date	X	Date

Authorized Signature(s) (as it/they appear in the financial institution's records; all authorized persons must sign)

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Insurance's consumer toll-free 1-800-927-HELP, by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free 1-800-434-0222, or by accessing the Department of Insurance's web site www.insurance.ca.gov.

For Agent Only

Please list all disability policies you have issued to the applicant that are still in force and all disability policies issued in the past 5 years that are no longer in force and submit with the application, as required by Insurance Code Section 10197(c):

Date	Name of Policy	Name and Address of Insurance Company
____________	____________	____________
From: Mo./Yr.		Name
		____________
		Address
____________		____________
To: Mo./Yr.		City/State

(Attach additional sheets if necessary)

I have read and understand the application. I additionally certify that I have given the applicant the "Guide to Health Insurance for People with Medicare" and an outline of coverage for the policy applied for, and that the applicant has both Parts A and B of Medicare. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

SIGNED AT

Agent's Signature ____________ Date of Signature ____________ (City and State) ____________

Print Agent's Name ____________ Agent No. ____________

Street Address ____________ Telephone No. ____________

City ____________ State ____________ ZIP ____________

Amount Paid With Application $____________

Send Agreement and I.D. Card To: ❏ Agent ❏ Subscriber

Name of person who completed this application: ____________

PRIORITY PROCESSING

Complete the Other Side of this form to enroll in the Optional Monthly Checking Account Deduction Authorization for Seniors.

Include with one month's dues in application pocket behind check.

Attach a blank check marked "VOID".

A deposit slip is not acceptable.

This Application will be returned to you after processing.

WE ADVISE YOU TO SAVE THIS NOTICE AS IT MAY BE IMPORTANT TO YOU IN THE FUTURE

The following applies only to the Classic F Plan portion of the AdvantageCare Plan.

According to the information you have furnished, you intend to lapse or otherwise terminate an existing Medicare supplement policy or Medicare Advantage plan and replace it with a contract to be issued by Blue Cross of California. Your plan contract to be issued by Blue Cross of California will provide 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. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Select coverage is a wise decision.

Statement to applicant by plan, solicitor, solicitor firm, or other representative:

A. I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement contract is being purchased for the following reason (check one):

❏ Additional benefits.

❏ No change in benefits, but lower premiums.

❏ Fewer benefits and lower premiums.

❏ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.

❏ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

____

❏ Other. (Please specify.) ____

B. You may not be immediately eligible for full coverage 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 or contract.

C. State law provides that your replacement Medicare Select contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.

D. If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and refund your prepaid or periodic payment 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.

E. Do not cancel your present Medicare supplement coverage until you have received your new contract and are sure you want to keep it.

Blue Cross Senior Services Toll-Free Number

Monday – Thursday:
8:00 a.m. to 6:00 p.m.

Friday:
8:00 a.m. to 3:00 p.m.

1-800-333-3883

MAILING ADDRESS – **Applicant: Please return application to agent or mail to:**

Blue Cross of California
P.O. Box 9063, Oxnard, CA 93031-9063

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