SENIOR ENROLLMENT APPLICATION

For Seniors with Medicare Parts A and B Please complete entire application.

1. Choice of Coverage

Please check the box for your choice of coverage.

☐ Blue Cross Senior Select℠ ☐ Blue Cross Senior Select Plus

A two-party contract (Member and Spouse rate) is available for eligible couples, at their option. Both spouses must be age 65 or older, enrolled in both Parts A and B of Medicare, and apply for the same plan.

If you and your spouse are applying for a two-party contract, please check this box: ❏ Yes ❏ No

If yes, you and your spouse will each have to fill out your own application, list the other spouse's name and Social Security Number, and submit both applications together.

Name of Your Spouse ______________________ Your Spouse's Social Security Number ______________________

Please enclose only one check for the applicable rate for the two of you.

2. 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

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

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

If you are applying for a 2-party contract, or wish to be added to an existing contract, please enclose one check for the applicable 2-party rate.

3. Health History

If the answer to any of the following questions is "Yes", you are not eligible for coverage unless you are applying from certain Blue Cross Plans that are not Medicare Supplements or you are 65 or older and applying within six (6) months of your initial enrollment in Medicare Part B. You must already be enrolled in Medicare Parts A and B to apply for these plans. Applicant must answer all questions in this section.

	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 transplant (except cornea), cirrhosis of the liver or complications of diabetes such as amputation or loss of sight?	☐	☐

4. Medical Information

Name of Primary Care Physician ______________________ Telephone (______) ______________

Address ____

List all prescription drugs currently prescribed for your use: (If none, write "none") ______________

____

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

____

____

If applying for, but not accepted for **Blue Cross Senior Select Plus**, if I qualify, I would like to be enrolled in **Blue Cross Senior Select**. Yes ☐ No ☐

5. 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 clause in the Blue Cross contract 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 have left nothing out regarding my past or present health. 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.

Important Information for Applicant (Please Read)

- You do not need more than one Medicare supplement policy or contract.
- 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 Medi-Cal or Medicaid and may not need a Medicare supplement policy or contract.
- The benefits and premiums under your Medicare supplement contract will 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 contract will be reinstituted if requested within 90 days of losing your Medi-Cal or Medicaid eligibility.
- Counseling services may be available in your area to provide advice concerning your purchase of Medicare supplement coverage and concerning medical assistance through the Medi-Cal or Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

6. Autorization & 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 I decide not to sign this authorization, you may decline to enroll me 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 800-333-3883, Fax 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	X	
Print Name	**Signature**	**Date**
X	X	
Print Name	**Signature**	**Date**

6. Autorization & Agreements (continued)

If the authorization is signed by a personal representative, on behalf of the individual, complete the following:

Personal Representative: Print Name **Relationship to Individual**

X

Signature **Date**

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. I AM ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER I 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 and Standard Plan A 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**

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)

7. Authorization To Obtain Medical Information For Claim Processing

I authorize the 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 to give Blue Cross of California or affiliate ("Blue Cross") its agents, employees, designees, or representatives, including my Blue Cross agent or broker, 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) of me or any of my dependents having Blue Cross coverage. I understand that this information may be collected in connection with the review, investigation or evaluation of any claim for benefits, or of any inquiry or grievance.

I also authorize Blue Cross to disclose all such medical or personal information related to myself or any covered dependent, to a health care provider, a health care service plan, a self-insurer, or any insurance company for the purposes of investigating or evaluating any claim for benefits.

This authorization is effective immediately and shall remain in effect for use in connection with any claim for benefits incurred for as long as any Blue Cross coverage may be in effect. 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.

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 and the Medicare Select Review and Grievance Procedures (for Medicare Select Plans) and "Outline of Medicare Supplement Coverage and Premium Information" as required by California Insurance 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.

Any dispute between me and Blue Cross of California and or its affiliates must be resolved by binding arbitration, if the amount in dispute exceeds the jurisdictional limits of the Small Claims Court, any such dispute will be resolved not by lawsuit or resort to court process, except as California law provides for judicial review or arbitration proceedings. Under this coverage, both Blue Cross of California and I are giving up the right to have any dispute decided in a court of law before a jury. Blue Cross of California and the member also agree to give up any right to pursue, on a class basis, any claim or controversy against the other.

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

PRIORITY PROCESSING

Please Tear Off and 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.

Include a blank check marked "VOID".

A deposit slip is not acceptable.

8. General Information

To the best of your knowledge:

Do you have another Medicare supplement insurance policy or health care service plan in force? ❑ Yes ❑ No

If yes, insurance company's name ______________________________

Street Address ______________________________

City ______________________________ State ________ Zip ______________

(Attach additional sheets if necessary.)

Do you have any other health coverage that provides benefits that this Medicare supplement contract would duplicate? ❑ Yes ❑ No

If yes, with which company______________________ What kind of coverage ______________

Address______________________________ Phone Number (______) ______________

If the answer to either of the above questions is yes, do you intend to replace any of your medical or health insurance coverage with this policy? ❑ Yes ❑ No

Please be aware that if you are 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.

Are you covered by Medi-Cal or Medicaid? ❑ Yes ❑ No

If yes, do you qualify for ❑ Qualified Medicare Beneficiary (QMB) assistance, ❑ Specified Low-Income Medicare Beneficiary (SLMB), or ❑ other Medi-Cal or Medicare benefits?

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.

Agent's Signature ______ Date of Signature ______ SIGNED AT (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: ______

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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