Application for Medicare Supplement

for Individuals Age 65 and Older or Individuals with Disabilities who are enrolled in Medicare



Blue Cross Blue Shield of North Dakota (BCBSND) is an independent licensee of the Blue Cross & Blue Shield Association.



Application for Medicare Supplement Please type or print in black ink. Press firmly.

20000018	Rev. 6-11
BPN	

1. APPLICA	NT'S INFORMATION	e type of print in otack		GROUP ROLL		
Name Registered Last	l with Medicare	First M.I.		Social Security Number – –		
Mailing Address		State in Which You Resid		Home Phone () – Work Phone () –		
City State		Zip Code				
		Sex □Male □Female	Birth Date (mm-dd-yy)	Heightin	Weight (lbs)	
Have you used tol	bacco in any form in the past I	12 months? □ Yes □ No	Requested Effective	Date (mm-dd-yy)		
2. COVERA	GE INFORMATION					
HEALTH coverage: New Coverage (I do not have existing BCBSND coverage now) Change in Existing BCBSND Coverage Medicare Supplement Plan: Plan A Plan C Plan F High Deductible Plan F Plan L Plan N Plan F Disabled (under age 65)		ZA. Payment Method I wish to be billed: □ Bill Direct □ Automatic Payment Withdrawal (If chosen, complete the information below.) Include voided check Name as Shown on Account (print) Name of Financial Institution City Bank Routing Number (first 9 digits on lower left side of check) Account Number □ Checking Account □ Savings Account Is This a Business Account? □Yes □No				
		I hereby authorize my financial institution to deduct the current premium from my checking or savings account and remit the same to BCBSND. This authorization is to continue in effect until revoked by me in writing. A 31-day notice is needed when cancelling an automatic withdrawal authorization. BCBSND is not responsible for overdrafts and fees due to insufficient funds in my account. Authorized Signature as Shown on Account Retain a copy of this authorization for your records.				
	RE ID CARD INFORMA	TION				
your claims if this not correct. You must be enro	r Medicare card. unable to process s information is Cla blled in both Is F Hoth Hoth Is Medical Part B	Health SOCIAL SECUL im Number (include alpl im Line in the control of the cont	na characters)			
4. WORKEI	RS' COMPENSATION/I	NO-FAULT				
□Yes□No Are □Yes□No Are	you currently receiving or h you currently receiving or h	ave received workers' cor ave received no-fault ben	npensation benefits? efits?			
Injury Date (mm			pany Providing Benefits	Company Pl	none Number	

5. QUESTIONS

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 answe	r all questions to	the best of your kno	wledge:				
□Yes □No	Did you turn ag	e 65 in the last 6 mor	nths?				
□Yes □No	Did you enroll i 6 months?	n Medicare Part B in	the last	\Rightarrow	If yes, what is the effective date?		
□Yes □No	through the state NOTE TO APP a "Spend-Down	l for medical assistante Medicaid program LICANT: If you are program" and have please answer NO to	? participating i not met your	n 🖒	If yes, will Medicaid pay your premiums for this Medicare supplement policy? □Yes □No Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? □Yes □No		
	than original M example, a Med HMO or PPO), below. If you are "END" blank.	rage from any Medica edicare within the pa icare Advantage plan fill in your start and e still covered under	ast 63 days (for a, or a Medican end dates this plan, leave	r re	If you are still covered under the Myou intend to replace your current new Medicare supplement policy? Was this your first time in this type INO Did you drop a Medicare supplement in the Medicare plan? If you are still covered under the Medicare your current new Medicare supplements are supplemented.	coverage with this Yes No e of Medicare plan? ent policy to enroll	
	SIAKI	END		<u> </u>	Policy Number		
□Yes □No	Do you have an policy in force?	other Medicare supp	lement		If so, with what company, and wha	t plan do you have?	
	other policy? If other policy, lea	lates of coverage und you are still covered ve "END" blank. –END	under the		If so, do you intend to replace your supplement policy with this policy	? □Yes □No	
	SIAKI	END			Policy Number		
insurance within the past 63 days? (For example, an employer, union, or individual plan) What are your dates of coverage under the		If so, with what company, and who	at kind of policy?				
		Policy Number					
	START	END		_			
6. ACKNO	OWLEDGEMEN	T AND SIGNATU	RE (This fo	rm mus	st be signed and dated)		
I acknowled	lge receipt of th	e Outline of Cove	rage and Gu	ide To I	Health Insurance For People	With Medicare.	
I understand covered by the application of Plan is issued I understand application.	I that BCBSND r his Benefit Plan t or advance premi d to me. I have re I and agree that a I further underst	eserves the right to o the provider of ca um payment and the ad this application ny false statements	accept or de are. I further he same shal in its entiret or omission submits an a	cline the underst l not be y and ce s may vo	is application. I assign any paya and that no contractual right i considered accepted unless or ertify the information is accura oid any Benefit Plan(s) issued b on or files a claim with intent to	ments for services s created by this until the Benefit te and complete. based on this	
X		_	_	X			
Applicant	l's Signature	Date Sig	ned	Age	nt's Signature (If Applicable)	Date Signed	
Agent Number		Agent Name			s shall list any other health insura		
Amount Received	l with App Voucher Nu	mber			o the Applicant (use extra paper if not policies sold which are still in force.	ecessary).	

2. List policies sold in the past five years which are no longer in force.

If you have questions or require assistance when completing this application, please contact one of our offices listed below:

Home Office

4510 13th Ave. S. Fargo, ND 58121 Phone: (701) 277-2227

Fargo District Office

4510 13th Ave. S. Fargo, ND 58121 Phone: (701) 282-1149

Grand Forks District Office

American Office Park 2810 19th Ave. S. Grand Forks, ND 58201 Phone: (701) 795-5340

Dickinson Office

1674 15th St. W., Suite D Dickinson, ND 58601 Phone: (701) 225-8092

Bismarck District Office

1415 Mapleton Ave. Bismarck, ND 58503 Phone: (701) 223-6348

Minot District Office

1308 20th Ave. SW Minot, ND 58701 Phone: (701) 858-5000

Devils Lake Office

425 College Dr. S., Suite 13 Devils Lake, ND 58301-3537 Phone: (701) 662-8613

Jamestown Office

300 2nd Ave. NE, Suite 132 Jamestown, ND 58401 Phone: (701) 251-3180

Williston Office

1137 2nd Ave. W., Suite 105 Williston, ND 58801 Phone: (701) 572-4535



Member Services Toll-Free (800) 342-4718



Visit us on the web www.BCBSND.com

LIMITATIONS AND EXCLUSIONS

I understand limitations and exclusions outlined in the relevant Benefit Plan may apply.

Benefits are available for services that are involved in the treatment of a Preexisting Condition only after this Benefit Plan has been in effect for a period of 6 months, beginning on the Effective Date of coverage. A Preexisting Condition is any condition for which medical advice was given or treatment was recommended by or received from a Health Care Provider within a 6-month period prior to the Effective Date of this Benefit Plan. This period may be reduced by aggregate days of membership under Qualifying Previous Coverage, if continuous until at least 63 days prior to the Subscriber's Effective Date of coverage under this Benefit Plan.

If I discontinue Medicare Part B Medical Insurance Benefits, it shall be my responsibility to notify BCBSND of the change.

FOR YOUR INFORMATION

- 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 coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid through the state Medicaid Program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Special Low-Income Medicare Beneficiary (SLMB).

SUSPENSION OF COVERAGE

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 that 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 the 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 the suspension.