APPLICATION FOR

Senior Blue®

Medicare Supplement Plans

WYOMING

An independent licensee of the Blue Cross and Blue Shield Association

Instructions for completing this application

To ensure complete and accurate processing of your application, PLEASE:

- **Complete all applicable sections**
- **Print legibly**
- **Use an ink pen**
- **Do not use correction fluid**

Checklist:

_____ / _____ / _____ Requested Effective Date

- ☐ **Did you indicate the benefit plan for which you are applying?**
- ☐ **If you want your premium automatically deducted from your checking account, have you included a voided check and completed the Automatic Withdrawal Authorization Form?**
- ☐ **Have you answered each health question (if applicable)?**
- ☐ **If you made any changes to this application, did you initial that change?**
- ☐ **Have you signed and dated the application?**

Name (First, Middle, Last)				
Address		City	State	Zip Code
Home Phone No. ( )	Date of Birth	My Social Security No.		Sex ☐ M ☐ F
Are you a Wyoming resident? ☐ YES ☐ NO	Is this application for reinstatement of a policy which was suspended? ☐ YES ☐ NO			

MEDICARE INFORMATION (As shown on your Medicare ID Card)

1. Medicare Number ☐☐☐☐–☐☐☐–☐☐☐☐
2. Hospital Insurance (Part A) Effective Date: (month/day/year) _____
3. Medical Insurance (Part B) Effective Date: (month/day/year) _____

OTHER INSURANCE 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. Mark YES or NO with an "X".
To the best of your knowledge,

(1) (a) Did you turn age 65 in the last 6 months? ☐ YES ☐ NO
(b) Did you enroll in Medicare Part B in the last 6 months? ☐ YES ☐ NO
(c) If yes, what is the effective date? _____

(2) 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,
(a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ YES ☐ NO
(b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ☐ YES ☐ NO

(3) (a) 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 ___/___/____
(b) 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
(c) Was this your first time in this type of Medicare plan? ☐ YES ☐ NO
(d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ YES ☐ NO

(4) (a) Do you have another Medicare supplement policy in force? ☐ YES ☐ NO
(b) If so, with what company, and what plan do you have?
_____
(c) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ YES ☐ NO

(5) 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, what kind of policy, and why is your coverage ending?
_____
_____
(b) What are your dates of coverage under the other policy? START ___/___/____ END ___/___/____
(If you are still covered under the other policy, leave "END" blank.)

HEALTH QUESTIONS

Do not complete the following questions if applying during open enrollment or the guaranteed issue period.

Height _____ft. _____in. Weight _____lbs.

How many times have you been confined to a hospital within the past two years? _____
(Give full details on each confinement below.)

Diagnosis Date Length of Stay Was Surgery Performed? Name & Address of Hospital

_____

_____

_____

Have you received any other medical or surgical treatment or been advised to have medical or surgical treatment with in the past two years? Yes _____ No _____ (Give full details below.)

Diagnosis Date Length of Treatment Name and Address of Doctor

_____

_____

_____

Please list any and all current medications you are taking. Attach additional sheet if necessary to list all medications.

Medication Dosage Diagnosis Name and Address of Doctor

_____

_____

_____

CONTRACT INFORMATION

Check the Senior Blue Plan for which you are applying: ☐ Plan A ☐ Plan G ☐ High Deductible Plan G ☐ Plan K ☐ Plan N

APPLICANT SIGNATURE

I have read the statements and the agreement and certification on the back of this application.

Applicant's Signature X _____ Date: _____
(If POA, submit copy of legal authorization)

Agent Name _____ Signature: _____
(Please Print)

Agent No. _____

List any health insurance policies sold to this applicant in the past 5 years. _____

_____

Are any policies still in force? ☐ YES ☐ NO If yes, please give details: _____

_____

FOR BLUE CROSS BLUE SHIELD OFFICE USE ONLY

Basic _____ GRP/Roll _____ OED _____

APPR _____ REF _____ INIT _____ Date _____ Salesperson # _____

STATEMENTS:

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 that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your 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 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.
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).
7. Premium payments may be made on a calendar month or calendar quarter basis. For example, a monthly premium would be for the first day of a month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31.

AGREEMENT AND CERTIFICATION:

I hereby apply for coverage with Blue Cross Blue Shield of Wyoming under the terms and conditions as stated in the Medicare Supplement Agreement, and as provided for under applicable State or Federal law, including the non-duplication provisions which preclude duplication of payment for services, portability of pre-existing conditions and coverage replacement provisions.

I hereby certify that the statements made on this application are true; that this application correctly describes my present health status; and that I am in good health except as expressly explained in the application.

I understand that Blue Cross Blue Shield of Wyoming reserves the right to accept or decline this application in whole or in part as provided by State or Federal law. I further understand I will not be eligible for coverage until the Medicare Supplement Agreement is actually issued by Blue Cross Blue Shield of Wyoming. (I will be notified of the effective date if accepted.)

I realize that any misrepresentations or omissions in the application will invalidate the Agreement.

I understand that upon acceptance of my application, my coverage will become effective on the date established by Blue Cross Blue Shield of Wyoming and that the Medicare Supplement Agreement together with this application or applicable documents, shall constitute my entire agreement with Blue Cross Blue Shield of Wyoming.

I realize that any deposit of dues by Blue Cross Blue Shield of Wyoming does not constitute acceptance of this application and does not waive any right to deny this application.

I understand that no condition will be covered under the terms of this Agreement if medical advice was given, or treatment was recommended by, or received from, a physician within 2 months before the effective date of the coverage, until 90 days after the effective date of coverage. However, the 90 days will be reduced by the period of creditable coverage if applicable to you and you are enrolling during your initial open enrollment period, or if you have a Guaranteed Issue right.