Blue Care Network of Michigan

A nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association

MyBlue Medigap℠ Application for Coverage

Print in black or blue ink or type your information. For your convenience, you can also complete this application online at **MiBCN.com.** You must complete all sections. Information indicated with an asterisk (*) is required for processing. Review your application for completeness and accuracy, and sign and date where requested. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be viewed online at **MiBCN.com/privacy.**

Step 1: Choosing your plan option

Choose your MyBlue Medigap plan option (check one)*

Plan option: ☐ **Plan A** ☐ **Plan C** ☐ **Plan F**

Please indicate how you want us to bill you (check one): DO NOT SEND PAYMENT WITH THIS APPLICATION

☐ **Automatic deduction from your bank account** (check one choice below, and complete the Automatic Payment Plan form and send it to us along with this application)

☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

☐ **Send me a bill in the mail**. I want to pay my premium (check one):

☐ Quarterly ☐ Semi-annually ☐ Annually

Month requested for coverage to start: _____ ***Note:*** **Unless otherwise indicated, coverage always begins the first day of the month following receipt of your completed application.**

Step 2: Information about you

Last name*	**First name***	**M.I.***	**Suffix (if applicable)** ☐ Sr. ☐ Jr. ☐ Other _____

Street address*	**City***	**State**	**ZIP***
		MICHIGAN	

Primary phone*	**Secondary phone**	**E-mail address** *(By providing your e-mail address, you give us permission to send you e-mails about benefits and health topics)*
( ) _____ - _____	( ) _____ - _____	

Date of birth*	**Gender***	**Weight***	**Height***	**Have you used any form of tobacco within the past 12 months?***
____ / ____ / 19_____	☐ Male ☐ Female	_____ pounds	____ feet ___ inches	☐ Yes ☐ No

If you are submitting your application within 6 months after you first enrolled for benefits under Medicare Part B or if you are within the guaranteed issue period, your rate will not be affected by your weight, height, smoking status, claims experience, receipt of health care or medical condition.

9-digit Social Security number*	**Michigan driver's license or Michigan ID number***
___ ___ ___ – ___ ___ – ___ ___ ___ ___	

Please refer to your red, white and blue Medicare Health Insurance card to complete this section.

Please fill in these blanks so they match the information on your Medicare card.*

MEDICARE HEALTH INSURANCE

1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY

_____

MEDICARE CLAIM NUMBER

___ ___ ___ – ___ ___ – ___ ___ ___ ___ – ___

IS ENTITLED TO **EFFECTIVE DATE**

HOSPITAL (PART A) ____ – ___ – _____

MEDICAL (PART B) ____ – ___ – _____

Continue to next page

*Required for us to process your application.

Step 2: Information about you, *continued*	
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 Medigap policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medigap plans and entitled to the Special Enrollment rate (see outline of coverage). Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark the Yes or No boxes below with an X. To the best of your knowledge:	
Did you turn age 65 in the last 6 months?	☐ **Yes** ☐ **No**
Did you enroll in Medicare Part B in the last 6 months? If so, what is the effective date? _____	☐ **Yes** ☐ **No**
Are you currently covered by Medicaid? (State assistance) [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 so, will Medicaid pay your premiums for this Medigap policy? ☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ **Yes** ☐ **No**
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. If you're still covered under this plan, leave "End date" blank. **Start date** ____/____/_____ **End date** ____/____/_____ If you're still covered under the Medicare plan, do you intend to replace your current coverage with this new Medigap policy? ☐ **Yes** ☐ **No** Was this your first time in this type of Medicare plan? ☐ **Yes** ☐ **No** Did you cancel a Medigap policy to enroll in the Medicare Advantage plan? ☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
If you had coverage under a Medicare Advantage policy and it is no longer in force, please indicate the reason: ☐ CMS terminated the certification of the organization or plan. ☐ The Medicare Advantage Organization stopped offering Medicare Advantage plans. ☐ The Medicare Advantage Organization stopped offering coverage in the area in which you live. ☐ You moved out of the geographic service area of your Medicare Advantage plan. ☐ Voluntarily disenrollment because plan violated a material provision of the policy or insurer materially misrepresented the policy's provisions in marketing the policy to individuals. ☐ Other: _____	
Did you enroll in Medicare Advantage when you became eligible for Medicare Part A and Part B, but voluntarily disenrolled from the plan within 12 months of the effective date of enrollment?	☐ **Yes** ☐ **No**

Continue to next page

Step 2: Information about you, *continued*

Do you have, or did you have, another Medigap policy in force? ☐ **Yes** ☐ **No**

If so, with what company and what plan? _____

_____

What are your dates of coverage under that policy? (If you are still covered under the other policy, leave "End date" blank.) **Start date** ____/____/_____ **End date** ____/____/_____

If your Medigap policy is no longer in force, indicate the reason:

- ☐ Involuntary disenrollment because insolvency of insurer or bankruptcy of organization offering the coverage
- ☐ Voluntarily disenrollment because plan violated a material provision of the policy or insurer materially misrepresented the policy's provisions in marketing the policy to individuals.

If so, do you intend to replace your current Medigap policy with the MyBlue Medigap policy?

☐ **Yes** ☐ **No**

Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) ☐ **Yes** ☐ **No**

If so, with what company? _____

Type of policy _____ Policy number _____

What are your dates of coverage under that policy? (If you are still covered under the other policy, leave "End date" blank.) **Start date** ____/____/_____ **End date** ____/____/_____

If the plan is no longer in force, what was the reason your coverage ended?

- ☐ Involuntary disenrollment because the group plan sponsor stopped offering coverage
- ☐ Voluntary disenrollment

If available, please include proof of prior coverage termination with this application. If you're applying online, please mail proof of prior coverage termination along with a copy of your MyBlue Medigap online enrollment confirmation to Mail Code C411, Blue Care Network of Michigan, P.O. Box 5043, Southfield, MI 48086-5043.

Conditions of coverage

- I am applying for MyBlue Medigap coverage. I certify that I am enrolled in both Part A and Part B of Medicare.
- I authorize Blue Care Network of Michigan (BCN) to obtain from providers of service and hospitals the medical records relating to me necessary to the administration of my contract with BCN.
- I assign BCN my entire right of recovery of the cost of hospital and medical services paid for by BCN against any person or organization as a result of accident or disease, including injuries or disease claimed under worker compensation laws or acts whether by redemption award, voluntary payment or otherwise.
- I understand that the benefits I will be eligible for are described in the MyBlue Medigap certificate and that the BCN outline of coverage is only a summary.
- I certify that the above information is true, correct and complete to the best of my knowledge and belief. I understand the information will be used in reviewing my application and administering coverage and my failure to provide complete and accurate answers or my submission of false or misleading information may result in denial of claims or cancellation.
- I certify that I am a permanent resident of Michigan and have a valid Michigan driver's license or Michigan ID card, and reside at least 6 months of each year at my permanent residence in Michigan.

Continue to next page

Step 3: Please read and sign

- You do not need more than one Medigap policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you are age 65 or older, you may be eligible for benefits under Medicaid and may not need a Medigap policy.
- Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- Your insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medigap policy will be suspended 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 Medigap 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 Medigap 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, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate 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.
- Counseling services may be available in your state to provide advice concerning your purchase of Medigap insurance and concerning Medicaid. A copy of the *Guide to Health Insurance for People with Medicare* is available on the Medicare Web site at **medicare.gov/publications/pubs/pdf/02110.pdf**.

I have read and agreed to the terms on this form. I understand that approval of this application and coverage effective date will be determined by Blue Care Network of Michigan. If I cancel within the first 30 days of the effective date of this coverage, I will be entitled to a refund of my previous premium payment. **Please note: The reasonable costs for any health services paid by BCN during that time period will be deducted from the refund and I will be responsible for payment of reasonable fees for any health care services I received.**

I have received and read (1) the outline of coverage section of this brochure outlining MyBlue Medigap coverage, and (2) the information concerning replacement of existing health coverage with the MyBlue Medigap certificate.

Your signature	**Date**

Be sure that you have completed all portions of this application. Mail completed form to:

Mail Code C411, Blue Care Network of Michigan, P.O. Box 5043, Southfield, MI 48086-5043

Use one application for each person. For faster processing, you may use the online enrollment application at **MiBCN.com** instead of submitting a paper application. If you have questions, please call 877-4MY-BLUE (469-2583) or contact your Blue Care Network insurance agent. TTY users should call 800-481-8704.

Note to applicant:

If you are replacing a Medigap or Medicare Advantage policy with this MyBlue Medigap policy, you must also complete the following page. If you're purchasing this policy through a Blue Care Network agent or broker, your agent or broker must also sign this form.

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NOTICE TO APPLICANT REGARDING REPLACING MEDIGAP INSURANCE OR MEDICARE ADVANTAGE
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

Blue Care Network of Michigan
P.O. Box 5043, MC C411
Southfield, MI 48086-5043

According to your application, you intend to drop or otherwise terminate an existing Medigap or Medicare Advantage plan and replace it with a policy or certificate to be issued by Blue Care Network of Michigan. Your new policy or certificate provides 30 days within which you may decide without cost whether you desire to keep the policy or certificate.

Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

Your insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy or certificate for similar benefits to the extent such time was spent or depleted under the original coverage.

If, after thinking about it carefully, you still wish to drop your present coverage and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the insurer to deny any future claims and to refund your premium as though your policy or certificate 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.

You should review this new coverage carefully and compare it with all disability and other health coverage you now have and terminate your present coverage only if, after due consideration, you find that purchase of this Medigap coverage is a wise decision. Do not cancel your present policy until you have received your new certificate and are sure that you want to keep it. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ Fewer benefits and lower premiums
- ☐ No change in benefits, but lower premiums
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment _____
- ☐ Other (Please specify) _____

The "Notice to Applicant" was delivered to me on: ***Date***_____

_____ _____

Applicant's signature ***Applicant's printed name***

_____

Applicant's address

Return this form with your application materials. Be sure to save a copy for your records.

Statement to applicant by insurer, agent or other representative:

I have reviewed your current medical or health coverage. The replacement of coverage involved in this transaction does not duplicate your existing Medigap or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medigap coverage or leave your Medicare Advantage plan, to the best of my knowledge.

_____ _____

Signature of Agent, Broker or other representative *Date*

_____

Printed name and address of Agent or Broker

To Agents: Paper enrollment forms must be keyed into **bcbsm.com/agent** or submitted to the Managing or General Agent within 24 hours of accepting the paper enrollment form from the applicant. Agents must complete this form in its entirety. ***Please print.***

Managing/General Agent name	Health Care Administrators			**MA/GA code**	0	6
Producing Agent name	First	Last		**Producing Agent code**		
Association or Chamber name				**Assoc/Chamber code**		
Name of person entering enrollment information online	First	Last	**BCBSM badge no.**	E	**BCBSM source code**	

IMPORTANT NOTE: Enrolling an individual in a Medigap plan requires that you provide **Policy/Certificate Name, Policy/Certificate Number, Start Date/Termination Date (if applicable)** for each health insurance policy, certificate, or contract that you have sold the applicant. In the space below, list all health insurance policies sold by you that are still in force, or sold within the past five years and are no longer in force. For online enrollment, please enter this information into the area indicated on the online form in the "Agent/Office use" section.

For agent use

List all health insurance policies sold by you to the enrollee that are still in force, or sold within the past five years and are no longer in force.

Name of Policy or Certificate	Policy or Certificate Number	Start Date mm/dd/yyyy	Termination Date mm/dd/yyyy

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Authorization Agreement for Automatic Payments MyBlue Medigap℠

Our automatic payment plan offers the convenience of paying your health care premium automatically from your bank account. No need to write checks, mail payments or worry about late payments. To participate, simply fill out and mail in this enrollment form. Please include a blank, voided check or a deposit slip from your designated account for verification. If you bank online, enter your account number and bank routing number.

Your name		
Address	**Phone** ( )	
City	**State**	**ZIP**

Authorization for automatic payments

I hereby authorize Blue Care Network of Michigan, hereinafter called BCN, to withdraw from my checking/savings account amounts necessary to pay the premium owed by me under my BCN contract. This authority will remain in effect until I notify you, or the bank listed below, in writing to cancel it in such time as to afford the bank a reasonable opportunity to act on the cancellation. . ☐ Yes ☐ No

Bank name	**Branch**	
City	**State**	**ZIP**
Account type ☐ **Checking account** ☐ **Savings account**		
Bank account number	**Bank routing number**	
Account holder name		**Date**

Withdrawals will occur on the fifth day of each month. We will send you written notification of the date your automatic payments begin. Keep a copy of this application for your records.

Mail this form and your voided check or deposit slip to:

Mail Code C411
Blue Care Network of Michigan
P.O. Box 5043
Southfield, MI 48086-5043

BCN use only		
Member's contract number	Process date	Effective date
Processed by		