




# MyBlue Medigap<sup>SM</sup> 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**.

<b>Step 1: Choosing your plan option</b>																														
Choose your MyBlue Medigap plan option (check one)*																														
Plan option:	<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan C	<input type="checkbox"/> Plan F																											
Please indicate how you want us to bill you (check one): <b>DO NOT SEND PAYMENT WITH THIS APPLICATION</b>																														
<input type="checkbox"/> <b>Automatic deduction from your bank account</b> (check one choice below, and complete the Automatic Payment Plan form and send it to us along with this application)																														
<input type="checkbox"/> Monthly		<input type="checkbox"/> Quarterly																												
<input type="checkbox"/> Semi-annually		<input type="checkbox"/> Annually																												
<input type="checkbox"/> <b>Send me a bill in the mail.</b> I want to pay my premium (check one):																														
<input type="checkbox"/> Quarterly		<input type="checkbox"/> Semi-annually																												
<input type="checkbox"/> Annually																														
Month requested for coverage to start: _____ <b>Note: Unless otherwise indicated, coverage always begins the first day of the month following receipt of your completed application.</b>																														
<b>Step 2: Information about you</b>																														
Last name*		First name*																												
		M.I.*																												
		Suffix (if applicable) <input type="checkbox"/> Sr. <input type="checkbox"/> Jr. <input type="checkbox"/> Other _____																												
Street address*		City*																												
		State MICHIGAN																												
ZIP*																														
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* ____ / ____ / 19____		Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female																												
Weight* _____ pounds		Height* ____ feet ____ inches																												
Have you used any form of tobacco within the past 12 months?*																														
<input type="checkbox"/> Yes <input type="checkbox"/> 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.		<table border="1" style="width:100%; border-collapse: collapse;"> <tr style="background-color: #e0e0e0;"> <td style="text-align: center;">MEDICARE</td> <td style="text-align: center;"></td> <td style="text-align: center;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="3" style="text-align: center;">1-800-MEDICARE (1-800-633-4227)</td> </tr> <tr> <td colspan="3" style="text-align: center;">NAME OF BENEFICIARY</td> </tr> <tr> <td colspan="3" style="text-align: center;">_____</td> </tr> <tr> <td colspan="3" style="text-align: center;">MEDICARE CLAIM NUMBER</td> </tr> <tr> <td colspan="3" style="text-align: center;">_____ - _____ - _____</td> </tr> <tr> <td style="text-align: center;">IS ENTITLED TO</td> <td colspan="2" style="text-align: center;">EFFECTIVE DATE</td> </tr> <tr> <td style="text-align: center;">HOSPITAL (PART A)</td> <td colspan="2" style="text-align: center;">_____ - ____ - _____</td> </tr> <tr> <td style="text-align: center;">MEDICAL (PART B)</td> <td colspan="2" style="text-align: center;">_____ - ____ - _____</td> </tr> </table>		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)	_____ - ____ - _____	
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Please fill in these blanks so they match the information on your Medicare card.*																														

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?**

Yes  No

If so, what is the effective date? \_\_\_\_\_

**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.]

Yes  No

If so, will Medicaid pay your premiums for this Medigap policy?  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.**

Yes  No

**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

**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 reinstated 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 reinstated 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](http://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
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**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.**



**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):

- |   |  |
|---|--|
| <input type="checkbox"/> Additional benefits  | <input type="checkbox"/> No change in benefits, but lower premiums   |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D | <input type="checkbox"/> Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment _____ |
| <input type="checkbox"/> Fewer benefits and lower premiums  | <input type="checkbox"/> 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*





# Authorization Agreement for Automatic Payments

## MyBlue Medigap<sup>SM</sup>

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.

<b>Your name</b>		
<b>Address</b>	<b>Phone</b> (    )	
<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Authorization for automatic payments</b>		
<p>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.</p> <p style="text-align: right;"><input type="checkbox"/> Yes    <input type="checkbox"/> No</p>		
<b>Bank name</b>	<b>Branch</b>	
<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Account type</b> <input type="checkbox"/> <b>Checking account</b> <input type="checkbox"/> <b>Savings account</b>		
<b>Bank account number</b>	<b>Bank routing number</b>	
<b>Account holder name</b>		<b>Date</b>

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

<b>BCN use only</b>		
Member's contract number	Process date	Effective date
Processed by		