Application for Legacy Medigap Coverage

Blue Cross Blue Shield of Michigan

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

Print in black or blue ink or type your information and complete all sections as indicated. Review your application for completeness and accuracy, and sign and date where requested. **We may reject your application if you do not provide all required information or sign this form.** Allow three weeks for processing. The information provided here will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be viewed online at www.bcbsm.com/home/privacy_practice.

Step 1. Choose your plan options (check one)

☐ Plan A — $39.88 per month ☐ Plan C — $121.22 per month

When do you want your coverage to begin? (mm/dd/yyyy) ___/___/20___ Your coverage effective date is assigned by BCBSM.

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 your preference below, complete the Automatic Payment Plan form and send it along with this application)

☐ Monthly ☐ Quarterly

☐ Send me a bill in the mail. Note: You will be billed quarterly.

Step 2. Information about you

Last name	First name	M. I.	Suffix (Sr., Jr., etc.)

Street Address			

City	State	ZIP	Primary phone
	MI*		( ) ___ — _____

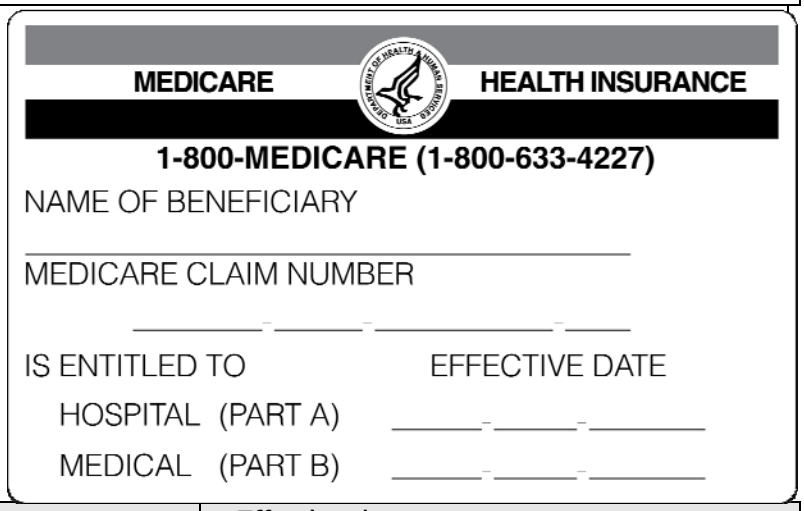
E-mail address (Optional) *You may receive e-mails about benefits, wellness and other health topics.*	Date of birth (mm/dd/yyyy)	Gender
	____/____/_____	☐ Male ☐ Female

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

Medicare information

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.



BCBSM Use only	CRD	Effective date

** You must be a permanent Michigan resident and reside in the state at least six months of each year.*

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Step 3. Coverage 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 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 (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
Are you a permanent resident of Michigan and reside here at least six months of the year?	☐ Yes ☐ No
Are you or your spouse currently employed? If yes, please provide the name of the employer for you _____ For your spouse _____	☐ Yes ☐ No
Are you eligible for employer-sponsored heath care through either employer?	☐ Yes ☐ No
Are you or your spouse retired?	☐ Yes ☐ No
If yes, please provide the name and phone number of your employer from where you retired _____ and/or your spouse's former employer _____	
Are you eligible for employer-sponsored health care through either employer as a retiree?	☐ Yes ☐ No
Does any employer fund any premium or contribute to an HRA for you as an active employee or as a retiree, or as the spouse of an active employee or retiree?	☐ Yes ☐ No
Does any employer pay for, or reimburse you as an active employee or as a retiree, or as the spouse of an active employee or retiree, for all or part of your health care coverage or provide you with a health care plan?	☐ 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.]	☐ Yes ☐ No
If yes, 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. (mm/dd/yyyy)	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

Continue to next page

Step 3. Coverage information, *continued*

Did you cancel a Medigap policy to enroll in the Medicare Advantage plan? ☐ Yes ☐ No

IMPORTANT: If you are currently enrolled in a Medicare Advantage plan and wish to enroll in Medigap, you must separately disenroll in writing from Medicare Advantage. Submission of this application does not automatically disenroll you from your current Medicare Advantage insurance carrier. Call your Medicare Advantage customer service department for information on how to disenroll from that plan and prevent duplication of coverage and/or a lapse in coverage. Medicare Advantage plans only allow disenrollment at certain times of the year.

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.
- ☐ Voluntary 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 Parts A and B, but voluntarily disenrolled from the plan within 12 months of the effective date of enrollment? ☐ Yes ☐ No

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

If yes, with what company? _____

Type of plan _____

Policy number _____

What are your dates of coverage under that policy? (If you are still covered under the other policy, leave "End date" blank.) (mm/dd/yyyy)

Start date ____/____/_____ End date ____/____/_____

Is your Medigap policy no longer in force? ☐ Yes ☐ No

If yes, please indicate the reason:

- ☐ Involuntary disenrollment because insolvency of insurer or bankruptcy of organization offering the coverage.
- ☐ Voluntary 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 yes, do you intend to replace your current Medigap policy with the Legacy Medigap policy? ☐ Yes ☐ No
- ☐ Other: _____

Continue to next page

Step 3. Coverage information, *continued*

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

If yes, with what company? _____

Type of plan _____

Policy number _____

Is this policy: ☐ a group health plan, or ☐ an individual policy you purchased on your own?

What are your dates of coverage under that policy? (If you are still covered under the other policy, leave "End date" blank.) (mm/dd/yyyy)

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 the coverage

☐ Voluntary disenrollment

If available, please include proof of prior coverage termination with this application.

Conditions of coverage

- I am applying for Legacy Medigap coverage. I certify that I am enrolled in both Part A and Part B of Medicare.
- I authorize Blue Cross Blue Shield of Michigan (BCBSM) to obtain from providers of service and hospitals the medical records relating to me necessary to the administration of my contract with BCBSM.
- I assign BCBSM my entire right of recovery of the cost of hospital and medical services paid for by BCBSM 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 Legacy Medigap certificate and that the BCBSM 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 six months of each year at my permanent residence in Michigan.

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Step 4: 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.
- 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. Failure to include all material 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 publication *Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare* is available on the Medicare website at www.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 Cross Blue Shield 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 BCBSM 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 Legacy Medigap coverage, and (2) the information concerning replacement of existing health coverage with the Legacy Medigap certificate.

Your signature	Date

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

Individual Underwriting — Mail Code 1124
Blue Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

If you have questions, please call 1-877-4MY-BLUE (469-2583). TTY users should call 1-800-481-8704.

Note to Applicant: If you are replacing a Medigap or Medicare Advantage policy with this Legacy Medigap policy, you must also complete the following page.

If you wish to enroll in the Automatic Payment program, you must complete the "Authorization Agreement for Automatic Payments" form on the last page of this booklet.

Blue Cross Blue Shield of Michigan

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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 Cross Blue Shield of Michigan
600 E. Lafayette Blvd.
Detroit, MI 48226-2998

According to your application, you intend to drop or otherwise terminate existing Medigap coverage or Medicare Advantage plan and replace it with a policy or certificate to be issued by Blue Cross Blue Shield 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.

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, comparing 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 policy and are sure that you want to keep it. The replacement policy is being purchased for the following reason(s) (check one):

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

_____ _____

Applicant's signature *Date*

_____

Applicant's printed name

_____

Applicant's address

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