APPLICATION FOR

SeniorBlue®

Medicare Supplement

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
- Use BLACK PEN

checklist:

- ☐ 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?
- ☐ Have you marked "YES" or "NO" to 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?

Wellmark. BlueCross BlueShield of Iowa
An Independent Licensee of the Blue Cross and Blue Shield Association

Application for Senior Blue

FB Member #	FB County #	Group Billing Unit	Monthly Premium	Policy Effective Date

Name *(First,Middle, Last)*

My Social Security No.

Address

Apt. #

My Medicare No. *(As Shown On My Medicare Card)*

City | State | Zip Code | County #

Medicare Part A (Hospital) Effective Date — Month Day Year

Medicare Part B (Medical) Effective Date — Month Day Year

Home Phone No. ( )

Date of Birth

Sex ☐ M ☐ F

Are you a resident of Iowa? ☐ NO ☐ YES

Is this application for reinstatement of a policy which lapsed due to nonpayment of premium? ☐ NO ☐ YES

Is this application for reinstatement of a policy which was suspended? ☐ NO ☐ YES

Contract Information

☑ Check the Senior Blue Plan for which you are applying:

☐ Plan A ☐ Plan C ☐ Plan E
☐ Plan F ☐ Plan J ☐ Guaranteed-Issue C

How do you want to pay your premiums?

☐ Direct Bill, if so on what basis:
☐ Quarterly ☐ Semi-Annually ☐ Annually

☐ Automatic Account Withdrawal, if so on what basis:
☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually
On what date: ☐ 1st of the Month ☐ 5th of the Month
Do you want it deducted from:
☐ Checking–attach a voided check (If applicant is not the payor, pre-authorization form (M-5779) is needed.)
☐ Savings–complete the pre-authorization form (M-5779)

To the best of your knowledge:

1. Do you have another Medicare supplement policy or certificate in force? ☐ NO ☐ YES
   If so, with which company: _____
   If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ NO ☐ YES

If "YES", read and sign the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance." Include the white copy of this notice with this application.If "NO " this policy cannot be issued.

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy? ☐ NO ☐ YES
   If so, with which company: _____
   What kind of policy: _____
3. Are you covered for medical assistance through the state Medicaid program:
   a. As a Specified Low Income Medicare Beneficiary (SLMB)? ☐ NO ☐ YES
   b. As a Qualified Medicare Beneficiary (QMB)? ☐ NO ☐ YES
   c. For any other Medicaid medical benefits? ☐ NO ☐ YES

Health Questions

You do not need to complete these health questions if you are applying for Plan A or for guaranteed-issue Plan C or if you are applying during the six-month open enrollment period which begins the month you first became both 65 or older and were enrolled in Medicare Part B.

1. Within the last two years,have you received medical advice or prescription drugs for liver problems,internal cancer , stroke, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS);or within the last two years have have you had heart or bypass surgery or angioplasty? ☐ NO ☐ YES
2. Have you received medical treatment or prescription drugs for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) and/or tested HIV positive? ☐ NO ☐ YES
3. Do you currently use an oxygen device or require dialysis for kidney disease? ☐ NO ☐ YES
4. In the last twelve months, has the cost of all your current prescription medication exceeded $600? ☐ NO ☐ YES

NOTE: The following statements are true if you are not applying during the six-month open enrollment period:

- If you answer "YES" to questions 1,2,or 3, you are only eligible to apply for Plan A or guaranteed-issue Plan C.
- If you answer "YES" to questions 1,2,3,or 4, you do not qualify for Plan J.

Applicant Signature

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

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

Date: _____ Amount Submitted: $ _____

Agent Name _____
(Please Print)

Signature _____

Agent No. _____

Parts **1** & **2** – Wellmark Part **3** – Agent Part **4** – Applicant

ACKNOWLEDGMENT OF NONDUPLICATION
(Medicare Supplement)

FOR OFFICE USE ONLY

Print Name:_____ SSN: _____

FOR COMPLETION BY AGENT :

I, _____ certify that I have done the following:
(Agent's Name)

1. Informed the undersigned applicant of the right to have all existing health insurance policies presently in force reviewed by me to determine whether any duplicate coverage will occur with the issuance of this contract.
2. Reviewed the policies listed below and have found that duplication will / will not (circle one) occur with the issuance of the following contract:

Company	Policy Number	Type of Policy

☐ Duplication will not occur because the above policy(ies) will be replaced by the applied for contract.
☐ No health policies in force at this time.
☐ Applicant has elected not to have policy(ies) reviewed.

List any health insurance policies you have sold to the applicant which are still in force.

Company	Policy Number	Type of Policy

List any health insurance policies you have sold to the applicant in the past five years which are no longer in force.

Company	Policy Number	Type of Policy

Date _____ Agent _____

FOR COMPLETION BY APPLICANT :

I certify that I have been informed of my right to have all of my existing health policies reviewed and:

☐ I have been informed that the policy for which I am applying will / will not (circle one) result in duplicate coverage.

☐ I have elected not to have my policies reviewed.

Iowa law prohibits the sale of Medicare supplement coverage which will provide an individual more than one Medicare supplement policy; therefore, my signature also certifies that if I have a policy in force today that will duplicate Senior Blue, I will cancel that policy upon notification of my acceptance for coverage by Wellmark Blue Cross and Blue Shield of Iowa.

Date _____ Applicant _____

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. 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

5. 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).

AGREEMENT AND CERTIFICATION

Your signature on the front of this application verifies that you have received a "Senior Blue Medicare Supplement Outline of Coverage," a "Guide to Health Insurance for People with Medicare," and a completed copy of this application.

Your signature also verifies that, to the best of your knowledge and belief, you have answered the questions on this application truthfully and completely and you understand that your coverage will not begin until this application and payment submitted are received and accepted by us and an effective date is assigned by us.

Your signature also verifies that you authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of Iowa when reasonably related to the health care coverage you have applied for. If any law or regulation requires additional authorization for release of medical records, you will give this authorization.