

**SECTION 4 – HEALTH HISTORY**

**THIS SECTION MUST BE COMPLETED BY APPLICANT**

IF APPLYING DURING THE OPEN ENROLLMENT PERIOD OR IF YOU ARE A GUARANTEED ISSUE ELIGIBLE PERSON, DO NOT COMPLETE THIS SECTION (Skip to Section 6)

If the answer to questions 1 through 7 is “Yes”, you will not be eligible for coverage.  
Check the box next to any conditions that apply to you.

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| 1. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility, or other care facility, or are you currently undergoing physical therapy? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Within the past 2 years, have you been hospitalized 2 or more times, or been confined to a nursing home for a total of 2 weeks or longer? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Within the past 2 years, have you been advised to have surgery (including a biopsy), therapy, diagnostic testing, or any treatment which has not yet been done? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Within the past 5 years, have you consulted a medical professional, sought treatment, had treatment recommended, received treatment (including injection therapy), been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:  |                          |                          |
| a. Heart or vascular conditions including but not limited to heart attack, open heart surgery, placement of a stent or defibrillator, heart valve replacement, angioplasty, any aneurysm, congestive heart failure, enlarged heart, peripheral vascular disease, coronary artery disease, irregular heartbeat, stroke, (TIA) transient ischemic attack or blood transfusion therapy? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Alzheimer’s disease, Parkinson’s disease, Lou Gehrig’s Disease (ALS), senile dementia or other senility disorder, organic brain disorder, any neurological disorder including spinal stenosis, any autoimmune disorder (including but not limited to Lupus, Rheumatoid arthritis, Multiple Sclerosis and Myasthenia Gravis)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Chronic Obstructive Pulmonary Disease (COPD), asbestosis, or emphysema? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Internal cancer, Leukemia, melanoma, Hodgkin’s disease, Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC), chronic kidney disease stages 3, 4 or 5, kidney/renal failure, dialysis, cirrhosis of the liver, chronic hepatitis B or C, organ transplant (except cornea), or amputation? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have diabetes:   |                          |                          |
| a. With complications including, retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. With uncontrolled high blood pressure in the past 2 years? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. With the use of insulin in the past 5 years? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. In the past 12 months have you had placement of a pacemaker or had a joint replacement? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Within the past 2 years, have you been confined in a facility for drug or alcohol abuse or a mental/nervous condition? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. In the past 2 years have you been treated for asthma, allergies, (or any chronic pulmonary condition not listed in Question 4c) with the use of inhalers, nebulizer or oxygen? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been treated for degenerative disc disease in the past 2 years? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you need the assistance of a wheelchair, cane, or walker for mobility purposes? .....   | <input type="checkbox"/> | <input type="checkbox"/> |

Please provide a list of any medications taken or prescribed to you in the past 5 years:

\_\_\_\_\_

\_\_\_\_\_

**SECTION 5 – MEDICAL INFORMATION**

Name of Primary Care Physician \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

**Application for Medicare Supplement Insurance**

**4. Health questions**

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

If the health questions are answered for an Open Enrollment or Guaranteed Issue application, the application cannot be processed and will be returned.

If any health questions are answered "yes" in Section 4 the applicant(s) will not qualify for this insurance with us.

	<b>Applicant:</b>	<b>A</b>	<b>B</b>
1. Are you dependent on a wheelchair or any motorized mobility device?	OY ON	OY ON	OY ON
2. Do any of the following apply to you? Currently hospitalized, confined to a bed, in a nursing facility or assisted living facility, receiving home health care or physical therapy	OY ON	OY ON	OY ON
3. At any time, have you been medically diagnosed, treated, or had surgery for any of the following? A. congestive heart failure, unoperated aneurysm, defibrillator B. leukemia, lymphoma, multiple myeloma, cirrhosis C. Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, multiple sclerosis, muscular dystrophy, cerebral palsy D. chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency, Addison's Disease E. any condition requiring a bone marrow transplant or stem cell transplant, any condition requiring an organ transplant	OY ON	OY ON	OY ON
4. Do you have diabetes? A. that requires use of insulin B. with complications including retinopathy, neuropathy, peripheral vascular or arterial disease or heart artery blockage C. with history of heart attack or stroke (at any time) D. treated with medication that has been changed or adjusted in the past 12 months because of uncontrolled blood sugar	OY ON	OY ON	OY ON
5. Within the past 36 months, have you been medically diagnosed, treated, or had surgery for any of the following? A. alcoholism, drug abuse B. cardiomyopathy, atrial fibrillation, anemia requiring repeated blood transfusions, any other blood disorder C. internal cancer, melanoma, Hodgkin's Disease D. hepatitis, disorder of the pancreas	OY ON	OY ON	OY ON
6. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following? A. enlarged heart, transient ischemic attack (TIA), stroke, peripheral vascular or arterial disease, neuropathy, amputation caused by disease B. myasthenia gravis, systemic lupus or connective tissue disorder C. osteoporosis with fractures, Paget's Disease, arthritis that restricts mobility or the activities of daily living D. any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or 3 or more medications for lung or respiratory disorder E. any lung or respiratory disorder and currently use tobacco products	OY ON	OY ON	OY ON
7. Within the past 12 months, have you been advised by a medical professional to have treatment, further evaluation, diagnostic testing, or any surgery that has not been performed or do you have any pending test results?	OY ON	OY ON	OY ON
8. Within the past 12 months, have you been medically diagnosed or, treated, or had surgery for a heart attack, artery blockage, or heart valve disorder?	OY ON	OY ON	OY ON
9. Have you had or been told you had, or been treated for any immune deficiency disorder, AIDS, or ARC?	OY ON	OY ON	OY ON
10. Within the past 12 months, have you been medically diagnosed with wet macular degeneration and have taken or are currently receiving injections?	OY ON	OY ON	OY ON

# Application for Medicare Supplement Insurance

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Applicant A Initials..... Applicant B Initials.....

## Health questions *continued*

11. Within the past 12 months, do any of the following apply to you?	Applicant: A	B
A. had a pacemaker implanted	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
B. had a PSA blood test greater than 4.5, under age 70, with no history of prostate cancer	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
C. had a PSA blood test greater than 6.5, age 70 or older, with no history of prostate cancer	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
D. had a seizure	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
12. Was your last blood pressure reading higher than 175 Systolic or higher than 100 Diastolic?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

Systolic is the upper number and Diastolic is the bottom number of a blood pressure reading.

### 5. Applicant A health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

.....  
 .....

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

.....  
 .....

3. **Prescribed medications**                      **Reason for medications (diagnosis)**

•	•
.....	.....
•	•
.....	.....
•	•
.....	.....

Use an additional sheet of paper if needed for explanation.

### Applicant B health history

If this is an Open Enrollment or Guaranteed Issue application, do not answer questions in this section.

1. Within the past 24 months if you have been medically diagnosed, treated, or had surgery for any brain, mental or nervous disorder, provide reason and diagnosis:

.....  
 .....

2. Within the past five years if you have been hospitalized, treated at an outpatient facility, or emergency room, provide reason and diagnosis:

.....  
 .....

3. **Prescribed medications**                      **Reason for medications (diagnosis)**

•	•
.....	.....
•	•
.....	.....
•	•
.....	.....

Use an additional sheet of paper if needed for explanation.

**If you are applying during an open enrollment or guaranteed issue period:  
SKIP SECTIONS G & H and GO TO SECTION I.** **Omaha Health Questions**

(Please see the enclosed material for explanation of the open enrollment and guaranteed issue periods.)

**G. Health Information**

**For all plans, answer questions 9-19. Note: An interviewer may call to confirm and verify the information you have provided on this application.**

**Part A: Medical Questions:** (If "YES" is answered to any of the following questions 9-15, that person is not eligible for coverage.)

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
9. Are you currently confined to a wheelchair or any motorized mobility device?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
10. Are you currently hospitalized, confined to a bed, in a nursing home or assisted living facility?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
11. Have you been medically diagnosed with, treated for, or had surgery for any of the following (Do not include surgery when answering G):		
A. Chronic kidney disease (Stages 3, 4, or 5), kidney failure, or kidney disease requiring dialysis? ...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Emphysema, chronic obstructive pulmonary disease (COPD), any other chronic pulmonary disorder or any cardio-pulmonary disorder requiring oxygen?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alzheimer's disease, dementia or any other cognitive disorder? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Parkinson's disease, multiple sclerosis or amyotrophic lateral sclerosis (Lou Gehrig's Disease), Huntington's disease, or cerebral palsy?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Systemic lupus, scleroderma or myasthenia gravis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. Chronic hepatitis or cirrhosis? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for Human Immunodeficiency Virus (HIV)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
12. Have you had an organ or stem cell transplant or been advised to have an organ or stem cell transplant (excluding cornea implants)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
13. Do you have Osteoporosis, and as a result, experienced a fracture? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
14. Do you have diabetes with complications including retinopathy, neuropathy, peripheral artery disease, peripheral venous thrombotic disease, stroke, transient ischemic attack (TIA), any heart disorder or any kidney disease?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
15. Do you have an implanted cardiac defibrillator? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

**Part B: Medical Questions:** (If "YES" is answered to any of the following questions 16-19 that person MAY not be eligible for coverage and is subject to an underwriting review.) If you would like consideration to be given to an application that contains a "Yes" answer to any question in Part B, attach an explanation stating how long the condition has existed and how it is being controlled.

To the Best of Your Knowledge and Belief:	Applicant A	Applicant B
16. Within the past two years, have you been treated for, or been advised by a physician to have treatment for:		
A. Coronary artery disease, angina, heart attack, cardiac angioplasty, bypass surgery or stent placement?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Cardiomyopathy, congestive heart failure, aortic or cardiac aneurysm, peripheral artery disease, peripheral venous thrombotic disease, vascular angioplasty, endarterectomy, carotid artery disease, any heart or heart valve disorder, atrial fibrillation, other heart rhythm disorder, or implantation of a pacemaker?.....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
C. Alcoholism or drug abuse? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
D. Any mental or nervous disorder requiring treatment (including hospital confinement)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
E. Internal cancer, lymphoma or melanoma? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
F. A stroke or transient ischemic attack (TIA)? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
G. Degenerative bone disease, spinal stenosis, rheumatoid arthritis, psoriatic arthritis, arthritis that restricts mobility or have you been advised to have joint replacement? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
17. Do you have diabetes with high blood pressure and have you:		
A. Taken more than two medications for either condition (insulin dependent or oral medications)? ...	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
B. Had any changes in your medications within the past two years? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
18. Have you been hospital confined three or more times in the past two years for a same or similar condition? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
19. Have you been advised by a medical professional to have treatment, further diagnostic evaluation, diagnostic testing, follow up visits or any surgery that has not been performed? .....	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

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**NOTE: Please verify the completeness and accuracy of the above statements as they may impact claim payment.**

Applicant Name: \_\_\_\_\_

**Health History / Medical Questions**

**Note:** If you are eligible for Guaranteed Issue or in your Open Enrollment period, you are not required to answer the following health questions. (Continue to page 9.)

**Please answer the following health history questions.**

1. What is your height?	Ft.	In.
2. What is your weight?	Lbs.	
3. When you first became eligible for Medicare, was it either because of disability or end stage renal disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Within the past 3 years, have you been diagnosed, treated, hospitalized or recommended for treatment, including drug therapy, by a physician or any other provider for any of the following:		
a. Diabetes with amputation, loss of sight or complications affecting the kidney?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Organ or tissue transplant (except cornea)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Cancer (excluding basal cell or squamous cell cancer of the skin)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d. Leukemia or Hodgkin's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e. Stroke, Transient Ischemic Attack (TIA), or mini-stroke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f. Alzheimer's disease, senility, dementia or brain disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g. Parkinson's disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h. Carotid artery disease, heart attack, or heart by-pass surgery or angioplasty?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i. Congestive heart failure or heart valve replacement?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
j. Nephritis or kidney failure?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
k. Cirrhosis of the liver or Hepatitis C?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
l. Multiple Sclerosis or neuromuscular disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
m. Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's disease)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
n. Respiratory or lung disease requiring use of oxygen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
o. Alcohol or chemical dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Within the past 3 years, have you been treated for or diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or human immunodeficiency virus (HIV) infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Within the past 2 years, have you been advised to have kidney dialysis, joint replacement, or surgery for the heart, arteries or intestines that has not yet been done?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Applicant Name: \_\_\_\_\_

<b>Health History / Medical Questions</b>		
7. Within the past 2 years, have you been hospitalized 2 or more times, or have you been confined to a nursing home or other care facility for 14 or more days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Are you currently confined, or has confinement been recommended within the next 6 months to a bed, hospital, nursing facility, or other care facility, or do you need the assistance of a wheelchair or a home health care agency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Do you need or receive help from any other person to perform any of the activities below because of health or physical difficulty? <ul style="list-style-type: none"> <li>• Taking Medications</li> <li>• Eating</li> <li>• Walking</li> <li>• Bathing</li> <li>• Dressing</li> <li>• Toileting</li> <li>• Moving from place to place in your home</li> <li>• Getting in and out of bed or chairs</li> </ul>	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Medical Authorization</b>
<p>I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me, including and without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.</p> <p>I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and shall remain valid for 24 months, unless revoked by me in writing, which I may do at any time by sending a written request to the Company. Any revocation will not affect the activities of the Company prior to receipt of the revocation.</p>

<b>SIGNATURE REQUIRED</b>	
<i>Must be signed <b>in ink</b> and dated to avoid processing delays.</i>	
Applicant: _____	Date:        /        /

## Questions?

Call us at our Customer Service toll-free number **877-384-9307**,  
 call your insurance agent at the number listed on page 5, or visit **www.bcbstx.com**.