Application for
Blue Shield of California Medicare Supplement plans

blue california

Here's how to apply

1 Provide ALL requested information and print clearly in all capital letters in black ink.

2 Sign and date in all places indicated.

3 Within 30 days of your signature date, please submit your completed application to:
Fax: (844) 266-1850 **Email**: msinstall@blueshieldca.com
Mail: Medicare Supplement Installation
P.O. Box 3008
Lodi, CA 95241-1912

4 It is required that a signed copy of this contract is made for your records. Be sure to keep the second copy of this application with all other important Blue Shield of California documents and information.

If you are a current member interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete this application.

Plan F Extra will only be available to applicants who attain age 65 before January 1, 2020 or first become eligible for Medicare benefits due to disability before January 1, 2020.

Personal information

First name	Middle initial	Last name

Home address

City	State	ZIP

Home telephone

Email address

I understand and agree that the email address I provide on this Application may be used by Blue Shield to contact me about my Blue Shield contract/policy. I understand that information sent to me by email could include important information about my coverage, renewal options, and any other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the email I provide on this Application. _____ **Intial**

Mailing address (if different from above)

City	State	ZIP

Billing address (if different from above)

City	State	ZIP

Gender: ☐ Male ☐ Female ☐ Non-binary

Date of birth
__ __ – __ __ – __ __ __ __
Month Day Year

Medicare Beneficiary Identification (MBI) number

I'm entitled to: ☐ Hospital (Part A) effective date_____ ☐ Medical (Part B) effective date_____

Please check the plan type you are applying for: ☐ A ☐ F Extra ☐ G ☐ G Extra ☐ N

Requested effective date: The 1st day of __ __ – __ __ __ __
Month Year

Language preference ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Are you currently a Blue Shield of California member? ☐ Yes ☐ No
If Yes, please provide member ID number

Household Savings Program[1]

If you and the other member of your household are age 65 or older and both members have, or are applying for the same plan (including any dental/vision plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses. Tobacco users are not eligible for the Household Savings Program.

Is the other member of your household enrolled in, or applying for, the **same** Blue Shield Medicare Supplement plan that you are applying for and share both addresses? ☐ Yes ☐ No

If "Yes," please provide the other household member:

Name

Medicare Beneficiary Identification (MBI) number

Blue Shield Medicare Supplement plan member ID (if available)

Please provide other household member's authorization to cancel their separate Blue Shield contract and enroll under the primary subscriber's agreement for the Household Savings Program by having the other household member sign below:

Signature of individual listed above:_____ Date:_____

Each individual must complete their own application if not already a current member. If both members are either new enrollees or existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise the existing member already enrolled on the requested plan type will be designated as the subscriber. The subscriber is responsible for payment of dues/premiums to Blue Shield and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled on the plan. Billing information and amounts due can/will be shared with both parties enrolled on the plan when calling Customer Care.

Dental PPO plans **(OPTIONAL)**

Dental plans and dental + vision package for Medicare Supplement plan members. Please see the page on **blueshieldca.com/medDental** for more information.

To sign up for Blue Shield dental coverage, select a plan below:

Dental plan options (check one):

☐ Specialty Duo℠ dental + vision package℠* ☐ Dental PPO 1000 ☐ Dental PPO 1500 ☐ No dental plan

Please note that Plan F Extra and Plan G Extra include a vision benefit. If you are interested in dental coverage and are also enrolling in Plan F Extra or Plan G Extra, please select the Dental PPO 1000 or Dental PPO 1500 plan to avoid duplicative coverage.

You can save $3 each month for the first six months on your dental or dental + vision plan rates if you enroll in a dental or dental + vision plan **at the same time** you enroll in any Blue Shield Medicare Supplement plan.[1]

Conditions of coverage

- Dental benefits aren't subject to health plan deductible requirements.
- If your dental or dental + vision coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Specialty Duo Dental + Vision package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.

1 Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

Current insurance coverage information (required for all submissions)

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 Medicare Supplement insurance contract, or that you had certain rights to buy such a contract, you may be eligible for guaranteed acceptance in one or more of our Medicare Supplement plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance.

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the space below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet. **I believe I qualify for guaranteed acceptance based on situation number** _____.

If applying for guaranteed acceptance under situation No. 2 on the enclosed Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form on the next page and submit with your completed enrollment application.

Please include a copy of the front and back of your current carrier ID card. Please also include a copy of the notice from your prior insurer with your application.

Please answer all questions to the best of your knowledge. (Please mark Yes or No below with an X.)

1 ☐ Yes ☐ No a. Did you turn 65 years of age in the last six months?

☐ Yes ☐ No b. Did you enroll in Medicare Part B in the last six months?

c. If Yes, what is the effective date?

2 ☐ Yes ☐ No Are you covered for medical assistance through California's Medi-Cal program? NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

If Yes,

☐ Yes ☐ No a. Will Medi-Cal pay your premiums for this Medicare Supplement plan contract?

☐ Yes ☐ No b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

3 ☐ Yes ☐ No a. Have 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)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave the "END" blank.
Start _____ Carrier name: _____ Plan type: _____
End _____ Reason for coverage ending: _____

If Yes,

☐ Yes ☐ No b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan contract?

☐ Yes ☐ No c. Was this your first time in this type of Medicare plan?

☐ Yes ☐ No d. Did you drop a Medicare Supplement plan contract to enroll in the Medicare plan?

4 ☐ Yes ☐ No a. Do you have another Medicare Supplement plan policy or certificate or contract in force?

b. If so, with what company? _____ What plan do you have? _____

☐ Yes ☐ No c. If so, do you intend to replace your current Medicare Supplement plan policy or certificate with this contract? If you answered yes, please complete the notice on the next page.

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

a. If so, what companies and what kind of policy?
Carrier name: _____ Carrier phone No.: _____
Plan type: _____ Current ID No.: _____

b. What are your dates of coverage under the other policy? (If you are still covered under this plan, leave the "END" blank.)
Start _____ End _____

6 ☐ Yes ☐ No Are you under age 65?

If Yes, a. Do you have end-stage renal disease? ☐ Yes ☐ No

You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-466-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's website (www.dmhc.ca.gov).

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE COVERAGE

According to question four on the previous page, you intend to lapse or otherwise terminate an existing Medicare Supplement policy or contract or Medicare Advantage plan and replace it with a contract to be issued by Blue Shield. Your contract to be issued by Blue Shield will provide 30 days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy or plan contract only if, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision.

Statement to applicant by plan, solicitor, solicitor firm or other representative:

1. I have reviewed your current medical or health coverage. To the best of my knowledge, the replacement of coverage involved in this transaction does not duplicate coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):
   - ☐ Additional benefits
   - ☐ No change in benefits, but lower premiums or charges
   - ☐ Fewer benefits and lower premiums or charges
   - ☐ Plan has outpatient prescription drug coverage and applicant is enrolled in Medicare Part D
   - ☐ Disenrollment from a Medicare Advantage plan
   - ☐ Reasons for disenrollment: Other (please specify):
2. If the issuer of the Medicare supplement contract being applied for does not impose, or is otherwise prohibited from imposing, preexisting condition limitations, please skip to statement 3 below. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
3. State law provides that your replacement Medicare Supplement contract may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The plan will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new coverage for similar benefits to the extent that time was spent (depleted) under the original contract.
4. If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application requesting that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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.
5. **Do not cancel your present Medicare Supplement coverage until you have received your new contract and are sure you want to keep it.**

Terms, conditions, and authorizations

Information regarding Medicare Supplement plan coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.

1 You do not need more than one Medicare Supplement plan policy or contract.

2 If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.

3 You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare Supplement plan contract.

4 If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5 If you are eligible for, and have enrolled in, a Medicare Supplement plan contract by reason of disability, and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

6 Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.

7 Receiving materials and communications electronically versus print: You may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website blueshieldca.com, as applicable. Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you. To receive printed materials in the mail, to opt out of email communications, please call **(800) 248-2341 TTY: 711** 8 a.m. – 5:30 p.m. Monday through Friday.

Conditions of membership

1 I understand this application and the Statement of Health, if applicable, together with the *Evidence of Coverage and Health Service Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.

2 I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.

3 Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.

4 I acknowledge receipt of the
• Summary of Benefits • Rate table • The Guide to Health Insurance for People with Medicare • a copy of this application.
With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided. I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's signature	**Date**
X	

Producer information (for producer use only, if applicable):

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant(s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

Review and select one of the following:

☒ I did not assist the applicant/applicants in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advice of any kind from me.

☐ I assisted the applicant/applicants in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.

Notice: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

FMO/Agency name (please print appointed agency name)	FMO/Agency ID No. (please print agency ID)
NoCobra.com, Inc.	342013121
Producer (writing agent) name (required) (please print writing agent name)	Producer (writing agent) SSN/TIN ID No. (required) (please print agent ID number)
Marc L. Harris	569695706

Producer email address	Producer fax number	Producer phone number
marc@nocobra.com	949-334-3478	949-713-7222
Producer's signature (required)	**Print name** Marc Harris	**Today's date (required)**

Applicant's statement of health

Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided.

If you qualify for guaranteed acceptance, do not complete this section. (See the Guaranteed Acceptance Guide for qualifying information.) Otherwise, please answer Yes or No to each of the following questions:

1	Have you, within the past five years, received treatment or been hospitalized for any of the conditions listed below? If Yes, please explain the condition and indicate the date of treatment at the end of this section.	
	☐ Yes ☐ No	a. Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
	☐ Yes ☐ No	b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
	☐ Yes ☐ No	c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
	☐ Yes ☐ No	d. Gastrointestinal disorders such as liver cirrhosis, hepatitis, ulcerative colitis, etc.
	☐ Yes ☐ No	e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
	☐ Yes ☐ No	f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*
	☐ Yes ☐ No	g. Cancer or malignant tumors.
	☐ Yes ☐ No	h. Have you received treatment or been hospitalized for any other condition than those listed above?
2	☐ Yes ☐ No	Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment at the end of this section.
3	☐ Yes ☐ No	Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement at the end of this section.
4	☐ Yes ☐ No	Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking, and the condition for which the medication is prescribed.
5	☐ Yes ☐ No	Have you used any tobacco-related products in the last 24 months?

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary, and sign and date each sheet.

Condition	Date	Explanation/current status
		Medication(s) for this condition? ☐ Yes ☐ No Name(s) and dosage:
		Medication(s) for this condition? ☐ Yes ☐ No Name(s) and dosage:

* California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

Signature†	**Date**

† Your signature is required in this section only if completing the Statement of Health.

Authorization for release of medical information

By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

If you qualify for guaranteed acceptance, do not sign this release. (See the Guaranteed Acceptance Guide for qualifying information.)

Signature	**Date**

(Do NOT sign here if you qualify for GUARANTEED ACCEPTANCE)

Payment information

To determine the monthly dues amount, refer to Blue Shield's rate tables included in this booklet. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an *Evidence of Coverage and Health Service Agreement*, and a member identification card as proof of approval.

Please choose one of the following options below for ongoing billing and payments.

☐ Quarterly billing ☐ Monthly billing

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our Easy$Pay℠ program[1]. To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at **blueshieldca.com** and access the Payment Center tab. You may also call Customer Service at **(800) 248-2341** TTY: **711** 8 a.m - 5:30 p.m. Monday through Friday. Requests to enroll in the Easy$Pay program may take up to two billing cycles for completion. Members should pay all paper bills received until a letter confirming registration in the Easy$Pay program is received.

1 Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.