Medicare Supplement Attained Age/Medicare Select Application OHIO

Anthem use only - DO NOT WRITE IN THIS AREA		Agent use only - DO NOT WRITE IN THIS AREA	
Certificate no.		Agent name	
Assigned effective date	UW Date	Agent Tax ID	Agent number
UW information		GA name	GA number

Check one.

I am applying for: ☐ New coverage ☐ Change to my current coverage: Certificate no. ______

Section A — Applicant Information (PLEASE PRINT; USE INK ONLY)

Last name	First name	MI	Sex ☐ Male ☐ Female
Home address	City	State	Zip code

Social Security no.	Date of birth	Age	Email address (optional)	Phone number ( )

Are you a legal resident of the U.S.? ☐ Yes ☐ No *If no, attach a copy of your green card or visa.*

Billing address information: (☐ For premium notices ☐ If mailing address different than above)

Last name (c/o)	First name	MI	
Street/P.O. Box	City	State	Zip code

SECTION B — MEDICARE INFORMATION (THIS INFORMATION MUST BE TAKEN FROM YOUR MEDICARE CARD.)

Medicare number alpha ( )	Hospital (Part A) effective date	Medical (Part B) effective date

Section C — Benefit Selection: Check Plan desired (select only one.)

Medicare Supplement Attained Age Plans (can use any hospital)	Medicare Select Plans (must use network hospital)
☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan G	☐ Plan C ☐ Plan F

Section D — Desired Effective Date

Indicate what month you desire coverage to start: / /	Effective dates are issued on the first of the month following the date the completed application is received by Anthem unless otherwise indicated. Upon approval, NO CHANGE to the effective date will be permitted.

Section E — Billing Information

Bill me at home: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually	**OR**	Bill me through ☐ Automatic Bank Draft (Your bank must be participating. Please complete Section I.)	Total premium submitted $ ______ Make check payable to **Anthem Blue Cross and Blue Shield.**

Medicare Supplement Plans are underwritten by Anthem Blue Cross and Blue Shield.
Anthem Blue Cross and Blue Shield is the trade name of Community Insurance Company.
An independent licensee of the Blue Cross and Blue Shield Association.
®Registered marks Blue Cross and Blue Shield Association.

(PLEASE COMPLETE OTHER SIDE.)

Section F This information must be completed UNLESS you are turning 65 years old or are over 65 years old and first enrolled in Medicare Part B.

IMPORTANT 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) If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for twenty-four (24) months. You must request this suspension within ninety (90) days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing Medicaid eligibility. If the Medicare supplement 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.
5) If you are eligible for, and have enrolled in, a Medicare Supplement policy 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 policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within ninety (90) days of losing your employer or union-based group health plan. If the Medicare supplement 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.
6) 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).

QUESTIONS

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 policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. ***Please include a copy of the notice from your prior insurer with your application.*** PLEASE ANSWER ALL QUESTIONS. PLEASE MARK YES OR NO.

1. a) Did you turn 65 in the last 6 months? ☐ Yes ☐ No
   b) Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
   c) If yes, what is the effective date? ____________________
2. Are you covered for medical assistance through the state Medicaid program? (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
   a) If yes, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
   b) If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium? ☐ Yes ☐ No
3. a) 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 below. If you are still covered under this plan, leave "END" blank.
   START DATE ____ / ____ / ____ END DATE ____ / ____ / ____
   b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ☐ Yes ☐ No
   c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No
4. a) Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
   b) If so, with what company, and what plan do you have? ____________________
   ____
   c) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No
   d) If so, state your reason for disenrollment from your current policy. ____________________
   ____
5. Have you had coverage under any other health insurance within the past 63 days? (for example, an employer, union, or individual plan) ☐ Yes ☐ No
   a) If so, with what company and what kind of policy? ____________________
   ____
   b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START DATE ____ / ____ / ____ END DATE ____ / ____ / ____

Section G Medical Questions

Answer the following medical questions. NOTE: If applying during your Medicare Open Enrollment period or for guarantee issue coverage DO NOT complete these questions. **Open Enrollment begins, for a period of six (6) months, on the first day of the month in which you are turning 65 years old or are over 65 years old and first enrolled in Medicare Part B.**

1. Are you currently hospitalized, bed-ridden, or confined to a nursing facility or wheelchair? ☐ Yes ☐ No
2. Have you been hospitalized three (3) or more times in the past 12 months? ☐ Yes ☐ No
3. During the past five (5) years have you been treated for heart disease including Angina or Atrial Fibrillation OR been hospitalized for any heart condition or had any type of amputation caused by disease? ☐ Yes ☐ No
4. Within the past three (3) years have you been treated for or been advised to seek treatment for:
   a. Chronic lung or respiratory condition including black lung, Chronic Obstructive Pulmonary Disease (COPD) or emphysema? ☐ Yes ☐ No
   b. Alzheimer's disease? ☐ Yes ☐ No
   c. Internal cancer or malignant melanoma? ☐ Yes ☐ No
   d. Cirrhosis of the liver? ☐ Yes ☐ No
   e. Mental or nervous disorder? ☐ Yes ☐ No
   f. Kidney dialysis? ☐ Yes ☐ No
   g. Insulin Dependent diabetes? ☐ Yes ☐ No
   h. Stroke or Transient Ischemic Attack (TIA)? ☐ Yes ☐ No
   i. Parkinson's disease? ☐ Yes ☐ No
5. Within the past two (2) years have you been advised to have surgery, treatment, (excluding non-prescription drugs), or to be hospitalized or confined to a nursing facility, but not done so? ☐ Yes ☐ No
6. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or any other abnormality of the immune system, or had a positive result on an HIV test? ☐ Yes ☐ No
7. Were you eligible for Medicare before age 65? ☐ Yes ☐ No
   If yes, explain disability ____________________

Section H Medical Details (Provide complete details for questions 1 through 7 here.)

Question no.	Name of condition, illness or injury	Symptoms, details of treatment & medications	Date of diagnosis	Date last treated	Name of physician

Current Medications Taken	Why Taken

Section I Automatic Bank Draft Authorization

If you completed Section E and selected Monthly Automatic Bank Draft, please complete this section. You **MUST** attach a **blank voided** check for checking account deduction OR a **blank** deposit slip for savings account deduction including bank name, account holder's name and account number. If you choose savings account deduction, **verify the correct routing number** through your bank/financial institution.

I authorize Anthem Blue Cross and Blue Shield to initiate premium deductions from the account indicated and the designated financial institution to debit the same account. I understand that this authorization is in effect until I notify Anthem that I no longer desire this service, allowing them reasonable time to act upon my notification. I understand Anthem and my financial institution have the right to discontinue the withdrawals if they wish to do so.

Account holder's name		Premium will be deducted on the fifth of the month. Deduct premium on the following basis:
Account holder's signature (if other than the applicant)		☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
Applicant's Social Security no.	Bank Transit/ABA no.	Deduct premium from: ☐ Checking account ☐ Savings account

(See next page to affix voided check or blank deposit slip.)

(PLEASE COMPLETE OTHER SIDE.)

If you selected Automatic Bank Draft as your method of payment, you must attach a voided check (for checking account withdrawal) or a blank savings deposit slip (for savings account withdrawal).

Attach

a blank (voided) check or

a blank savings deposit slip

here.

Section J	Significant terms, Conditions and Authorizations

I may not assign any payment under my Anthem Blue Cross and Blue Shield program.

I represent that the answers given to all questions on this application are true and accurate to the best of my knowledge and I understand they are being relied on by the insurer in accepting this application.

I understand that Anthem reserves the right to accept or decline this application in accordance with Ohio law and that no right whatsoever is created by this application. I also understand that this coverage, if approved, may exclude coverage for pre-existing conditions.

I understand that if I incur an illness or change in medical condition during the period of time between the application signature date and effective date that I must notify Anthem in writing of any such illness or change, and such notice shall be a condition precedent to coverage (this does not apply if I am applying during Open Enrollment or qualify for guarantee issue coverage.)

I understand Anthem may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Anthem automatic debit process and will only occur each time I send a check to Anthem. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure, and my payment by check constitutes acceptance of these terms.

Any material misrepresentation or significant omission found in this application may result in denial of benefits or rescission or cancellation of my coverage(s). By signing this application, I agree and consent to the recording and/or monitoring of any telephone conversation between Anthem and myself. A photocopy is as valid as the original. I understand I may request a photocopy.

I understand that Anthem may collect personal information about me from outside sources, and that both personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the HIPAA Privacy Regulations (45 C.F.R. Parts 160 and 164) and the Ohio Revised Code § 3904.13. I also understand that under the HIPAA Privacy Regulations and Ohio law, I have a right to see and correct personal information that Anthem collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Anthem.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

I acknowledge that I have received the **Guide to Health Insurance for People with Medicare.**

DISCLOSURE STATEMENT: If I am applying for a Medicare Select Plan, I understand the network restrictions of the coverage for which I've applied and acknowledge receipt of the following:

- Outline of Coverage
- Notice Regarding Replacement
- Network Hospital Directory
- Anthem's Quality Assurance Procedures and Grievance Procedures

I indicate understanding and assent to these terms by my signature below.

Applicant signature **X**	**Date**
Agent Sold Cases Only Agent shall list any other health insurance policies agent has sold to the applicant. List policies sold in the past five years which are no longer in force ________________	

Do not cancel your present coverage until you receive written notification from Anthem Blue Cross and Blue Shield that your new coverage is in force.