Medicare Supplemental Coverage Enrollment Form

with Health Statement (Select Option)

Kansas

Underwritten by BlueCross BlueShield Kansas Solutions

Complete this form to apply for enrollment in Medicare Supplement Coverage from BlueCross BlueShield Kansas Solutions. All sections must be completed unless otherwise stated. Once accurately completed, sign and date your enrollment form where indicated and mail it to us in the enclosed postage-paid envelope.

Section 1 – Applicant Information

CLEAR DATA

Please use the name listed on your Medicare card.

First Name _____ MI _____

Last Name _____ Suffix _____

Residential Address _____

City _____

State _____ ZIP Code _____ +4 _____ County _____

Mailing Address (if different from residential address) _____

City _____

State _____ ZIP Code _____ +4 _____

Gender ☐ Male ☐ Female

Date of Birth _____ / _____ / _____

Social Security Number _____-_____-_____

Phone Number (_____) _____-_____

E-mail Address _____

Do you live in the same household as another BlueCross BlueShield Kansas Solutions or Blue Cross and Blue Shield of Kansas Medicare Supplement policyholder? ☐ Yes ☐ No

If yes, provide household member's name and Medicare Supplement ID number:

Name _____

ID Number _____

Have you used any products containing nicotine (including e-cigarettes, vaping and nicotine patches) within the last 12 months? ☐ Yes ☐ No

Section 2 – Plan Selection and Effective Date

Select which plan you are requesting:

☐ Plan A ☐ Plan C* ☐ Plan F*
☐ Plan G ☐ Plan G (HDHP) ☐ Plan K
☐ Plan L ☐ Plan N

SELECT PLANS:

☐ Plan C Select** ☐ Plan F Select**
☐ Plan G Select** ☐ Plan K Select**
☐ Plan N Select**

_____ / _____ / _____
Desired Start Date for Coverage

***Plan C, Plan C Select, Plan F and Plan F Select are only available if you were first eligible for Medicare before 2020.**

**** If you requested a Select Plan, read the following statement and sign below.**

I have received and fully understand the information in the enclosed Outline of Coverage and the Select Network Service Area Map explaining the hospital network limitations with Select Benefit Plans. I understand if I choose to obtain inpatient hospital services from a hospital outside my hospital network service area, I may be responsible for applicable deductibles and insurance payments.

Signature required

Signature of Applicant or Authorized Representative _____

Date Signed _____ / _____ / _____

Section 3 – Dental Options (you may only select one)

I would like to enroll in BlueCare DentalPlus. ☐Yes ☐No

I would like to enroll in BlueCare DentalPlus PPO. ☐Yes ☐No

_____ /_____ /_____
Effective Date

Waiting Period: There is a 12-month waiting period from the effective date for the following services:

• Crowns, onlays and oral surgery • Dentures and bridges • Dental implants

The waiting period is waived if you were covered under another policy that covered major services and had at least 12 months of continuous major service coverage under that plan (credit will be given for less than 12 months). Waiting periods must be satisfied if there has been a lapse in coverage. Your previous coverage will be verified.

You may be eligible to receive credit towards this waiting period by submitting proof of coverage from your prior dental insurance carrier. Proof of coverage should include the following:

• Letter from dental carrier on their company letterhead
• List of major dental services covered by your policy
• Effective date and termination date

You may send this proof of coverage via email to **csc@bcbsks.com** or by post mail to PO Box 239, Topeka, KS 66601 within 60 days of your dental effective date with us.

Section 4 – Secure Options

I would like to enroll in Secure 300 Cancer Plan. ☐Yes ☐No

I would like to enroll in Secure Hospital Indemnity Plan. ☐Yes ☐No

Do you have health insurance coverage as an individual? ☐Yes ☐No

Are you presently covered by Blue Cross and Blue Shield of Kansas? ☐Yes ☐No

_____
If yes, provide ID Number

_____ /_____ /_____
Requested Effective Date

_____
Group Number (if applicable)

Your effective date must not be more than 6 months from today.

If applying for Secure 300 Cancer Plan:

Do you have cancer now or have you had cancer in the past 5 years in any form? ☐Yes ☐No

Section 4A – Secure Coverage Authorization

Please read the following important information and sign below to represent your application.

- **Applicable to Secure 300 applicants only:** I hereby authorize any licensed physician, practitioner, hospital, clinic, or other medical facility, insurance company, or any other organization, association or person who has or obtains information or knowledge of any person covered by this application, or of our health to give it to Blue Cross and Blue Shield of Kansas (BCBSKS). A photographic copy of this authorization should be as valid as the original. Your authorization for medical release is only valid for a period up to, but not extending beyond, 24 months.
- Any contract issued to you as a result of this application will be issued in reliance on information you provide on this form. If you intentionally or unintentionally fail to provide complete, accurate and correct information, the contract shall be rescinded with all premiums refunded to you, less amounts paid for benefits under the contract.
- No representative of BCBSKS or any other entity has the authority to waive any of the information required on this form to bind BCBSKS to coverage of the applicants, or to waive, alter or amend any provision of any contract which may be issued to you.
- I understand coverage is subject to the health of all applicants on this application remaining unchanged to the effective date of coverage. If any change in health occurs before the effective date of coverage, I understand I must notify the BCBSKS underwriting department at 800-432-0216.

Signature required

_____
Signature of Applicant or Authorized Representative

_____ /_____ /_____
Date Signed

Section 5 – Proxy Statement for Dental and/or Secure Coverage

I hereby appoint the board of directors ("Board") of Blue Cross and Blue Shield of Kansas, Inc., ("Company") as my proxy to act on my behalf at all annual meetings of the policyholders of the Company. This appointment shall include such persons as the Board may designate by resolution to act on its behalf. This proxy gives the Board, or its designee, full power to vote for me on all matters that may be voted upon at any annual meeting. This proxy, unless revoked, shall remain in effect during my membership in the Company. I may revoke this proxy in writing by advising the Company of such at least 10 days prior to any meeting. I may also revoke my proxy by attending and voting in person at any annual meeting.

☐ Yes ☐ No

Disclaimer: BlueCare DentalPlus and Secure Coverage are provided by Blue Cross and Blue Shield of Kansas.

Signature required

_____ _____ / _____ / _____

Signature of Applicant or Authorized Representative — Date Signed

Section 6 – Payment Selection

Choose your payment option **(mark only one)**:

☐ **Please bill me at home** (monthly billing).

– OR –

☐ **Please automatically draft my financial institution on a monthly basis.** Your next payment will be deducted from your account on or after the 28th of the month preceding coverage.

_____

Name of Authorized Signer

Financial Institution information (only complete if you selected automatic draft):

_____

Institution Name

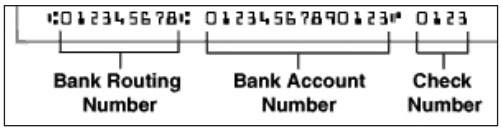
Please deduct from: ☐ Checking ☐ Savings

_____

Routing Number

_____

Account Number



By signing, I authorize BlueCross BlueShield Kansas Solutions, an independent licensee of the Blue Cross Blue Shield Association, to send my premium bill to the above-named financial institution for direct payment to my account. By checking this box, I attest that I am the account holder or have been authorized to use the account above. Further, in making this authorization, I agree that each monthly payment shall be the same as if it were an instrument personally signed by me. This authority is to remain in effect until revoked by me in writing. Should any draft entry be dishonored for any reason, or drawn after depositor's authorization has been withdrawn, BlueCross BlueShield Kansas Solutions agrees that the financial institution shall be relieved of any liability.

Signature required

_____ _____ / _____ / _____

Signature of Applicant or Authorized Representative — Date Signed

_____

Print Name

Section 7 – Medicare Information

Please refer to your Medicare Card to complete this section.

☐ Check box if you have **not** received your Medicare card and will call when you receive it.

_____ _____ _____

First Name — MI — Medicare Number

_____ _____ / _____ / _____ _____ / _____ / _____

Last Name — Hospital (Part A) Start Date — Medical (Part B) Start Date

Note: You must have both Medicare Parts A and B as of your desired Medicare Supplement effective date for coverage to be issued.

Section 8 – Coverage Information

1. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No

   If yes, what is the effective date? ____ /____ /____
3. Are you covered for medical assistance through the state Medicaid program? ☐ Yes ☐ No

   Note: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost", please answer NO to this question.

   If yes:

   a. Please mark which type of benefits you have:

      ☐ SLMB – Specified Low-Income Medicare Beneficiary (Medicaid pays your Part B premium only)

      ☐ QMB – Qualified Medicare Beneficiary (you have a Medicaid medical card)

   b. Will you be involuntarily losing Medicaid coverage? ☐ Yes ☐ No

      Note: Proof of loss will be required such as a letter from the Department of Children and Family Services.

      If yes, what is the date Medicaid coverage will end? ____ /____ /____
4. 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)?

   Not an employer, union or individual plan. ☐ Yes ☐ No

   If yes:

   a. Please enter your start and end dates. (If you are still covered under this plan, leave end date blank.)

      Start date: ____ /____ /____ End date: ____ /____ /____

   b. Was this your first time to be enrolled in a Medicare Advantage plan or Medicare HMO or PPO? ☐ Yes ☐ No

   c. If you are still covered under the Medicare plan or Medicare HMO or PPO, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No

   d. Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan or Medicare HMO or PPO? ☐ Yes ☐ No

   e. Did you lose coverage due to leaving the plan's service area? ☐ Yes ☐ No
5. Do you have another Medicare Supplement policy in effect? ☐ Yes ☐ No

   If yes, do you intend to replace your current Medicare Supplement policy with this policy? Note: You cannot have two Medicare Supplement policies at one time. ☐ Yes ☐ No
6. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)? ☐ Yes ☐ No

   If yes:

   a. Is this an employer sponsored plan? ☐ Yes ☐ No

   b. Is this plan with Blue Cross and Blue Shield of Kansas? ☐ Yes ☐ No

      If yes, provide Blue Cross ID number: _____ Group number: _____

      If no, provide name of company: _____

      Location of company: _____ Type of policy: _____

   c. What are the dates of coverage under this policy? (If you are still covered under this plan, leave end date blank.)

      Start date: ____ /____ /____ End date: ____ /____ /____

Section 9 – Information You Should Know

1. You do not need more than one Medicare supplement policy. Before you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
2. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
3. 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 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 Medicare supplement 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 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.
4. 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).
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 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. If you intend to cancel existing Medicare supplement insurance and replace it with a policy issued by BlueCross BlueShield Kansas Solutions, you will have 30 days to review your new policy. During this 30-day time period you may decide, without cost, whether you want to keep the policy. Review your new policy carefully and compare it with any accident and sickness coverage you have now. If, after you've reviewed all your policies, you decide to keep this Medicare supplement policy, you should cancel your present Medicare supplement coverage.
7. BlueCross BlueShield Kansas Solutions is not connected with or endorsed by the U.S. Government or the Federal Medicare Program.

Section 10 – Authorization

Releases Medicare Claims information to BlueCross BlueShield Kansas Solutions for faster claims processing.

I hereby authorize the Centers for Medicare and Medicaid Services to furnish BlueCross BlueShield Kansas Solutions, medical or other information required by it or others under the Title XVIII program or Title XIX state program to the extent necessary to process any claim under the agreement in effect with BlueCross BlueShield Kansas Solutions. I understand that if I should decide to rescind this authorization, some records could be released before the rescission has had time to take effect.

Signature required

_____ _____ / _____ / _____

Signature of Applicant or Authorized Representative — Date Signed

Section 11 – Health Statement

This section does not need to be completed if you are in your Initial Enrollment Period or are a Guaranteed Issue applicant.

Initial Enrollment: If you turned 65 in the last six months or if you became eligible for Medicare by reason of disability or End Stage Renal Disease (ESRD) in the last six months, are covered by Medicare Part A and have enrolled in Medicare Part B in the last six months.

Guaranteed Issue: If you lost or are losing your health insurance coverage and received a notice from your prior insurer indicating you were eligible for guaranteed issue of a Medicare Supplement policy, or you had certain rights to buy such a policy. **Please include a copy of the notice from your prior insurer with your application.**

All other applicants must complete this section.

1. Please provide your height and weight: Height _____ ft. _____ in. Weight _____ lbs.

2. During the **last two years**, have you been hospitalized overnight? ☐ Yes ☐ No
   If yes, please include details of the hospitalization(s) in question 7 of the Health Statement below.

3. Do you currently have a medical condition that requires you to spend more than **12 hours per day** in bed? ☐ Yes ☐ No
   If yes, please include details of the condition in question 7 of the Health Statement below.

4. Do you currently have a medical condition that required **ongoing** use of oxygen? ☐ Yes ☐ No
   If yes, please include details of the condition in question 7 of the Health Statement below.

5. In the **last five years**, have you been advised by a physician to have a procedure/surgery for any condition? ☐ Yes ☐ No
   If yes, please include details of the procedure/surgery in question 7 of the Health Statement below.

   If yes, has the procedure/surgery been performed or addressed? ☐ Yes ☐ No

Section 11 – Health Statement (continued)

6. Have you been diagnosed/treated (including taking medication) for any of the following conditions listed below? Check all that apply.

Kidney conditions
- ☐ Any kidney failure or insufficiency
- ☐ Chronic kidney disease
- ☐ Currently receiving dialysis
- ☐ End Stage Renal Disease (ESRD)

Cancers or tumors
- ☐ Cancer (excluding non-melanoma skin cancer)
- ☐ Malignant tumor or growth

Liver conditions
- ☐ Cirrhosis of the liver

Lung conditions
- ☐ COPD
- ☐ Emphysema
- ☐ Pulmonary Fibrosis

Heart, vascular or blood conditions
- ☐ Aneurysm
- ☐ Angioplasty
- ☐ Any heart disease requiring a defibrillator
- ☐ Bypass surgery
- ☐ Carotid artery stents
- ☐ Congestive heart failure
- ☐ Coronary/carotid artery blockage
- ☐ Heart attack
- ☐ Heart disease
- ☐ Heart surgery
- ☐ Peripheral bypass
- ☐ Stroke, Transient Ischemic Attack (TIA) or mini-stroke

Nervous system conditions
- ☐ Alzheimer's Disease or Dementia
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Systemic Lupus Erythematosus (SLE)

Transplants
- ☐ Bone marrow
- ☐ Organ transplant

Immune system conditions
- ☐ Any immune system disorder

Psychological/mental conditions
- ☐ Bipolar Disorder
- ☐ Major depression
- ☐ Schizophrenia

Substance abuse
- ☐ Alcohol abuse or alcoholism
- ☐ Drug abuse or chemical dependency

Brain or spinal cord conditions
- ☐ Paralysis

Other
- ☐ Hemophilia
- ☐ Infusion therapy for any condition

Diabetes
- ☐ Diabetes
- ☐ Diabetes with any of the following: circulatory problems, kidney problems or retinopathy

Section 11 – Health Statement (continued)

7. If you answered Yes to any of the above questions or selected any of the above conditions, please provide additional details below. If more space is needed, please list on a separate page and attach to your application.

Question # or condition category	Condition, procedure/ surgery or reason for hospitalization	Date of condition, last procedure/surgery or hospitalization	Overnight hospitalization? (Yes or No)	Additional details
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	
			[Select one]	

Section 11 – Health Statement (continued)

8. Please list any prescription medications you have taken or been prescribed in the **last two years**. If more space is needed, please list on a separate page and attach to your application.

Medication name	Dates taken/prescribed	Reason for medication

Section 12 – Authorization to Obtain and Disclose Protected Health Information

This section does not need to be completed if you are in your Initial Enrollment Period or are a Guaranteed Issue applicant.

Name of Insured _____ Date of Birth _____ / _____ / _____

Street Address _____

City _____ State _____ ZIP Code _____ +4 _____

I authorize any physician, hospital, pharmacy, pharmacy benefit manager, health insurance plan, consumer reporting agency, or any other entity that possesses any diagnosis, treatment, prescription, medical, or credit and financial information about me to furnish such information to BlueCross BlueShield Kansas Solutions for the purpose of evaluating my eligibility for insurance. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. This authorization shall be valid for 24 months from this date and may be revoked by sending written notice to BlueCross BlueShield Kansas Solutions at 1133 SW Topeka Blvd., Topeka, KS 66629-0001, Attention: Underwriting Department cc805B3. Your failure to execute this authorization may result in BlueCross BlueShield Kansas Solutions being unable to collect information relating to you and result in denial of your application for health insurance.

Your signature required

_____ _____ / _____ / _____
Signature of Individual Whose Information is to be Disclosed, or Authorized Representative Date Signed

_____
Print Name of Individual or Authorized Representative

Section 13 – Important Information

This section does not need to be completed if you are in your Initial Enrollment Period or are a Guaranteed Issue applicant.

To represent your Health Statement.

I understand any policy issued to me will be issued in reliance on the information I have provided on this health statement and that my signature verifies that I have read all the information on this form and represents that it is correct and accurate.

I understand that BlueCross BlueShield Kansas Solutions has the right to rescind the policy with all premiums refunded to me, less amounts paid for benefits under the policy for the following conditions:

1) If information received from future claims or supporting records within two years after the date the contract becomes effective indicates information provided on the health statement was incorrect, or

2) If such information received at any time indicates information provided in the health statement was materially misstated or was fraudulent.

I understand that no representative of BlueCross BlueShield Kansas Solutions has the authority to waive any of the information required on this form, to bind BlueCross BlueShield Kansas Solutions to provide coverage for me, or to waive, alter or amend the provisions of any policy, which may be issued to me.

I understand that by signing this health statement, I authorize any licensed health care provider, health care facility, insurance company or any organization or person who has or obtains information concerning me to give it to BlueCross BlueShield Kansas Solutions. This authorization is valid for a period no greater than two years.

I understand all coverage is subject to the health information provided on this form remaining unchanged to the effective date of coverage. If any change in health occurs before the effective date of coverage, I understand I must notify the BlueCross BlueShield Kansas Solutions Underwriting Department at 1-800-432-0216. (A photographic copy of this authorization shall be as valid as the original.)

Signature required

_____ _____ / _____ / _____

Signature of Applicant or Authorized Representative | Date Signed

Please insert your signed and completed enrollment form in the enclosed postage-paid envelope and return to BlueCross BlueShield Kansas Solutions.

Agent Use Only

_____ _____ _____ (_____) _____-_____

Agent First Name | MI | Agent ID Number | Phone Number

_____

Agent Last Name

Signature required

_____ _____ / _____ / _____

Agent | Date Signed