Plan65

Experience. Wellness. Everywhere.SM

BLUE PLAN65 SELECT

Application for Plan65 Membership

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

BlueCross BlueShield of Oklahoma

Blue Cross and Blue Shield of Oklahoma — Plan65
P.O. Box 806162, Chicago, IL 60680-8784

Plan65 | *Blue* Plan65 *Select* Medicare Supplement

YOU MAY APPLY FOR PLAN65 COVERAGE IF:

☑ You have Medicare Parts A and B; AND, ☑ You are an Oklahoma resident; AND, ☑ You are age 65 or older.

SELECT YOUR COVERAGE:

☐ Plan A ☐ Plan D ☐ Plan F

☐ Plan F (high deductible) ☐ *Blue* Plan65 *Select*

MAKE POLICY EFFECTIVE:

__ __ – __ __ – __ __ __ __

MONTH DAY YEAR

SELECT ONE PAYMENT OPTION:

A. Deduct from my checking account:
- ☐ MONTHLY
- ☐ 3 MONTHS
- ☐ 6 MONTHS

B. I prefer to be billed at my home:
- ☐ MONTHLY
- ☐ 3 MONTHS
- ☐ 6 MONTHS

C. Bill to my Blue Cross and Blue Shield group (see your employer / group benefits administrator for available coverage options).

NAME OF GROUP TO BE BILLED ____________ GROUP NUMBER ____________

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: ____________

Medicare Claim Number ☐☐ ☐☐☐ – ☐☐ – ☐☐☐☐ ☐☐ Sex ☐

Is Entitled to Effective Date

HOSPITAL (Part A) ____________

MEDICAL (Part B) ____________

TELL US ABOUT YOURSELF:

FIRST NAME OF APPLICANT	MIDDLE	LAST
MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)		
SEX ☐ M ☐ F	DATE OF BIRTH mm/dd/yyyy __ __ / __ __ / __ __ __ __	SOCIAL SECURITY NUMBER ☐☐☐ – ☐☐ – ☐☐☐☐

FINANCIAL INSTITUTION DEBIT AUTHORIZATION

PLEASE TAPE CHECK HERE

REMINDER
Your VOIDED CHECK (personal checking) or savings deposit slip must be attached here.

Please attach check with TAPE. Do not use glue, staples or paper clips.

Your Name
Your Address
Your City, State & Zip

Pay to the Order of ____________ $ ______

____________ Dollars

DEPOSITORY BANK OR BRANCH NAME
BANK ADDRESS

SAMPLE

12345678 123456 0 1001

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PLEASE ANSWER ALL THE FOLLOWING QUESTIONS:

To the best of your knowledge:

[Please mark Yes or No below with an "X"]

1. Have you been diagnosed with end-stage renal disease? ☐ Yes ☐ No
2. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
3. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
   (a) If yes, what is the effective date? ____/____/____
4. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
   (a) If so, with what company, and what plan do you have? ____________________
   (b) If so, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No
5. 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

Please attach supporting documentation if you answer yes to questions 6, 7 or 8 below.

6. 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)? ☐ Yes ☐ No
   (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare plan? ☐ Yes ☐ No
   (b) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   (c) Did you drop a Medicare supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No
7. 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" date blank.) START ____/____/____ END ____/____/____
8. If you lost or are losing other health insurance coverage, did you receive 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? ☐ Yes ☐ No
   If so, 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.

STATEMENTS:

(A) You do not need more than one Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) 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 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.

Statements continue on next page

(E) 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 equivalent to your coverage before the date of the suspension.

(F) 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).

AGREEMENTS AND SIGNATURES

- I understand that if I apply for Part A and B of Medicare and am not accepted, or at a future date lose Medicare entitlement, Plan65 will be of no value to me; therefore, it will be my responsibility to notify Blue Cross and Blue Shield of Oklahoma (hereafter referred to as BCBSOK) to terminate my Plan65.
- Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTI ON 1204 of the Oklahoma State Statutes.
- I hereby apply for membership with BCBSOK as stated in this application. I agree that if my application is accepted, membership will not be effective until the date indicated in written notification by BCBSOK at time of acceptance.
- Physicians, hospitals and other institutions are hereby authorized and have my consent to release, disclose and furnish to BCBSOK for its review and retention in connection with my application for health coverage, all information, records or copies of records relating to my medical history and conditions, including, but not limited to, diagnosis, treatment, care, surgery, and the dates thereof, past, present and future.
- I understand BCBSOK may deny benefits for the treatment of any condition which is not correctly represented in this application, and has the right to cancel membership and coverage and to recoup any monies paid as benefits prior to a determination by the Plan that a condition required to be reported was not correctly represented.
- Proof of Disclosure (for Blue Plan65 Select applicants only): I acknowledge that I have carefully and completely read and understand the Blue Plan65 Select booklet and directory that were sent to me with this application. I am aware of and understand the restrictions of the Blue Plan65 Select provider directory.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, make any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

I CERTIFY THAT ALL STATEMENTS AND INFORMATION SET FORTH ARE TRUE AND CORRECT

APPLICANT'S SIGNATURE X ______________________ DATE SIGNED: ______________

RESIDENCE PHONE NUMBER: ______________ ALTERNATE PHONE: ______________

PROXY STATEMENT: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature X______________________

Print Your Name as You Signed It:______________ Date Signed: ______________

FOR OFFICE USE ONLY	REP NO.	EFFECTIVE DATE	GROUP NO.	MISC CODE
FOR PRODUCER USE ONLY	PRODUCER NAME		PRODUCER SIGNATURE	PRODUCER ID NO.

FOR PRODUCER/AGENT USE ONLY (IF APPLICABLE)

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

BlueCross BlueShield of Oklahoma

Please retain copies of this form for both you and your applicant's records.

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Oklahoma. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and health coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage. Your should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement, or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

☐ Additional benefits.
☐ No change in benefits, but lower premiums.
☐ Fewer benefits and lower premiums.
☐ My plan has outpatient prescription drug coverage and I am enrolling Part D.
☐ Disenrollment form a Medicare Advantage plan. Please explain reason for disenrollment: ____________________

____

☐ Other (please specify): ____

1. Note: If the issuer of the Medicare supplement policy applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy 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.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

PRODUCER'S SIGNATURE X ______________________________ DATE SIGNED: ______________

APPLICANT'S SIGNATURE X ______________________________ DATE SIGNED: ______________

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FOR PRODUCER/AGENT USE ONLY (IF APPLICABLE)

PLAN65 MEDICARE SUPPLEMENT INSURANCE PRODUCER'S SUPPLEMENTARY APPLICATION FORM

BlueCross BlueShield of Oklahoma

Please retain copies of this form for both you and your applicant's records.

Applicant and Producer hereby acknowledge the following:

1. Producer inquired and made every reasonable effort to identify whether the Applicant already has accident and sickness insurance and the types and amounts of any such insurance. NOTE: If this policy is replacing another Medicare supplement insurance policy or Medicare Advantage insurance, Producer must complete the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."

2. Producer has sold the following medical or health insurance policies to the Applicant which are still in force.

____
____
____
____

3. Producer has sold the following medical or health insurance policies to the Applicant in the past five years which are no longer in force:

____
____
____
____

4. Producer furnished to the Applicant (and Applicant acknowledges receipt of the following documents:
   - ☐ Outline of Coverage
   - ☐ Guide to Health Insurance for People with Medicare (Buyer's Guide)
   - ☐ Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage (Complete only if Applicant is replacing an existing Medicare supplement policy)

PRODUCER'S SIGNATURE X______________________________ DATE SIGNED: ______________

APPLICANT'S SIGNATURE X______________________________ DATE SIGNED: ______________

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BlueCross BlueShield
of Oklahoma

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