

Medicare Supplement Application

Application Information

Your Name (first, initial, last)			Date of Birth (mm/dd/yy)	Age	Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
Mailing/Billing Address (street or route)			City, State, Zip Code				
Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Do you or have you ever smoked or used tobacco in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		Phone Number			
Are you applying during open enrollment? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have Part A of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective Date _____		<input type="checkbox"/> No	
		Do you have Part B of Medicare? <input type="checkbox"/> Yes <input type="checkbox"/> No		Effective Date _____		<input type="checkbox"/> No	
Are you currently enrolled with Blue Cross or Blue Shield? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, Identification Number		Headquarters City and State		Social Security Number	

We require a copy of the front and back of your current Medigap or Medicare Advantage enrollment card to determine eligibility for our programs. Failure to provide this information will result in a delayed effective date of this new coverage until this information is obtained.

Program Information

Classic BlueSM – Plan J Requested Effective Date: _____
 Classic Blue – Dental

The effective date on the policy will be the 1st of the month following receipt and acceptance of the application by the Blue Cross of Idaho Underwriting Department.

If, after health statement review, you are not eligible for coverage, we will refund your payment.

Mode of Payment

Monthly Automatic Bank Deduction **Direct Pay Statements:** Monthly (\$2.00 monthly billing fee will apply.)
 (First month's premium is required for all new applications. For automatic bank deductions, please include a voided check and sign the authorization agreement on the next page.)

Independent Producer Statement

- I hereby certify that I personally solicited and completed this application, that I personally asked each question on this application, and have accurately recorded the answers;
- That the answers to all of the questions are complete and accurate to the best of my knowledge and belief;
- That I have explained the eligibility provisions to the applicant and have not made any representations about benefits, conditions, or limitations of the policy, except through written material furnished by Blue Cross of Idaho;
- That I have verified the dates on the applicant's Medicare card.

Type of Company Appointment: Personal Agency (Name) _____

Independent Producer's Printed Name

Independent Producer's Signature

Date

Phone No.

Blue Cross of Idaho No.

Office Use Only

Program Number	Enrollee ID	Effective Date	Cr. Days	End Date	Class	Plan
Reason Code	Risk	Smoker	Bill Mode	Payment Received	Receipt ID	Auditor

Form No. 3-334PJ (01-06)

Other Carrier Information

Blue Cross of Idaho is currently considering a Medicare supplement application for the insured named below. The policy may or may not replace an existing Medicare supplement policy.

Insurer _____

Name of Insured: _____

Name _____

and _____

Address: _____

Other Carrier
Policy Number: _____

Health Statement

(Disregard this section if you are applying during the Medicare open enrollment period.)

Answer each question YES or NO. If YES, circle the specific condition. Then, in the chart below, write the number or letter in which the condition is listed, along with specific details.

- A. Has any company refused or restricted insurance on the applicant within the last year? YES NO
- B. Has the applicant been advised, in the past five years, to have surgery or hospitalization? YES NO
- C. Has the applicant ever had or been told he or she has any of the following:

	YES	NO		YES	NO
<ul style="list-style-type: none"> 1. Cancer, cyst, tumor, or tumorous growth (<i>malignant or benign</i>)? <input type="checkbox"/> YES <input type="checkbox"/> NO 2. Heart trouble, heart murmur, chest pain, stroke, or any other disorder of the blood or circulatory system? <input type="checkbox"/> YES <input type="checkbox"/> NO 3. An ulcer or any disorder or difficulty of the stomach, liver, intestines, or gall bladder? <input type="checkbox"/> YES <input type="checkbox"/> NO 4. Diabetes, thyroid disorder, or any disorder of the glands? <input type="checkbox"/> YES <input type="checkbox"/> NO 5. Convulsions, loss of consciousness, or paralysis? <input type="checkbox"/> YES <input type="checkbox"/> NO 6. Any disorder of the kidneys, bladder, or prostate? <input type="checkbox"/> YES <input type="checkbox"/> NO 		<ul style="list-style-type: none"> 7. Disease or disorder of the eyes? <input type="checkbox"/> YES <input type="checkbox"/> NO 8. Emphysema, tuberculosis, or removal of any part of lung? <input type="checkbox"/> YES <input type="checkbox"/> NO 9. Rheumatoid arthritis or osteoarthritis? <input type="checkbox"/> YES <input type="checkbox"/> NO 10. A physical examination, check-up, or doctor's visit within the past six months? <input type="checkbox"/> YES <input type="checkbox"/> NO 11. High blood pressure? (If YES, last reading _____) <input type="checkbox"/> YES <input type="checkbox"/> NO 12. Has the applicant ever tested positive for HIV infection? <input type="checkbox"/> YES <input type="checkbox"/> NO 13. Does the applicant have any illness, condition, or irregular symptoms not named above? <input type="checkbox"/> YES <input type="checkbox"/> NO 			

Letter or Number	Injury or Sickness	Date	Treatment	Result	Medication dosage, frequency	Doctor and/or Hospital

– FOR AGENT USE ONLY –

List policies you have sold to this applicant that are still in force. (Use extra sheet of paper if necessary.)

List policies you have sold to this applicant in the past five years that are no longer in force. (Use extra sheet of paper if necessary.)

Independent Producer Checklist

- Are the Medicare Part A and B effective dates filled in on the first page?
- Is the application completed in ink and signed by the applicant? (A dependent's signature is not acceptable.)
- Are all questions marked "yes" or "no?" (Check to make certain that specific condition(s), date(s) of occurrence, or date(s) last treated is (are) included and note if condition(s) is (are) resolved; make certain that condition explanation is complete; include prescription name, dosage, strength, duration and reason; if there are broken bones, are there any pins or hardware?)
- Is the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance section signed and dated?
- Did the applicant indicate the program they are applying for? (Only one program is allowed.)
- Is height and weight noted for the applicant listed on the application?
- Is the requested effective date on the first page filled in?
- Is the Authorization Agreement for Prearranged Payments section filled out and signed, and a voided check attached, if monthly automatic bank withdrawal is requested in the Payment Option section?
- Are all payments attached to the front of the application?
- If one check is written for split applications, is a breakdown of amounts to apply to each application included?
- Does the payment include a \$2.00 monthly billing fee if the applicant chose Monthly Direct Coupon?
- Did you verify eligibility on applicant's card?

Independent Producer Certification

1. Who actually completed this application? Applicant Independent Producer Other
If Independent Producer or Other, please explain: _____
2. Were you present at the time the application was filled out? YES NO
If NO, please explain: _____
3. Are you aware of any medical information relating to the applicant or any family member that has not been disclosed on this application? YES NO
If YES, please explain: _____
4. Was money collected from the applicant? YES NO Amount \$ _____

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions, or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

Independent Producer's Printed Name *Independent Producer's Signature* *Date* *Blue Cross of Idaho No.*

Type of Company Appointment Personal Agency (Name) _____
