



Medigap Security

GROUP COVERAGE APPLICATION FORM

A TO APPLY FOR MEDIGAPSECURITY...

Please reference the enclosed MedigapSecurity Outline of Coverage for the monthly premium based on your plan.

Check the ONE plan for which you are enrolling:

Plan A Plan B Plan C Plan F High Deductible Plan F Plan N

Desired effective date: _____

LAST Name: _____ FIRST Name: _____ Middle Initial: _____ Mr. Mrs. Ms.

Phone Number: - - Sex: _____

Birth Date: - - Social Security Number: - -

Permanent Residence Street Address: _____

City: _____ State: _____ ZIP Code: _____

Mailing Address (only if different from your Permanent Residence Address):

Street Address: _____ City: _____ State: ZIP Code:

Emergency Contact: _____

Phone Number: - - Relationship to You: _____

Email Address: _____

B PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please take out your Medicare Card to complete this section.

- Please fill in these blanks so they match your red, white, and blue Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join MedigapSecurity.



SAMPLE ONLY

Name: _____

Medicare Claim Number _____ Sex _____

Is Entitled To _____ Effective Date _____

HOSPITAL (Part A) - -

MEDICAL (Part B) - -

C DECLARATION

By signing the section J of the application, I elect coverage under the plan specified in section A of the form and for the persons listed there, and agree to abide by the conditions of the agreement and pay required premiums for the plan as selected. I hereby authorize any licensed physician, medical or medically related facility, insurance company, or other organization or person or institution that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and Highmark Blue Shield. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my Employer, Association, or Welfare board and Independence Blue Cross and Highmark Blue Shield.

8. **To all Producers:** Producers shall list other health insurance policies they have sold to the applicant.

Following Policies are still in force: _____

Following Policies are not in force: _____

Signature of Producer

G

IMPORTANT — PLEASE READ CAREFULLY

You do not need more than one Medicare supplement policy.

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

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

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 the Medicare supplement policy is no longer available, a substantially equivalent policy will be reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

H

IMPORTANT — PLEASE READ CAREFULLY (CONTINUED)

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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

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).

PLEASE READ AND SIGN BELOW

I hereby apply for the Policy coverage specified below. I understand that this application is subject to your acceptance and to the conditions and exclusions contained in the agreement. I agree to pay charges for these coverages as billed. I am covered by Medicare Part A and Part B.

I acknowledge and agree that any personally identifiable health information about me (“Protected Health Information”) is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Independence Blue Cross and/or Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Independence Blue Cross and/or Highmark’s Notice of Privacy Practices is available at www.site65.com.

I understand that the Independence Blue Cross/Highmark Blue Shield MedigapSecurity policy that I am applying for has a preexisting condition provision. Under this provision, benefits related to any preexisting condition will not be provided for six months after I enroll in MedigapSecurity. I also understand, however, that the preexisting condition provision will not apply to these benefits if, when I enroll in MedigapSecurity, I have already satisfied a preexisting condition provision for the benefits under another Medicare supplement policy or the preexisting condition provision is waived because I am an “eligible person” as defined by federal and Pennsylvania laws and regulations.

If I was previously enrolled under another Blue Cross® and Blue Shield® policy or a Medicare supplement policy with another company with a preexisting condition limitation, coverage under this policy for a preexisting condition limitation will only be excluded to the extent of the time that I did not satisfy the preexisting condition exclusion period under the previous policy and in no event shall such preexisting condition exclusion exceed six (6) consecutive months from the effective date of my coverage under this policy.

“Preexisting Condition” means a disease or physical condition for which medical advice or treatment has been received by me within one hundred eighty (180) days immediately prior to my initial effective date under this agreement or any endorsement made part of this policy.

I understand that I can find complete details of the program(s) in the Policy which I will receive after I return this Application Form.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature certifies that: 1) this person is authorized under State law to complete this application and 2) documentation of this authority is available upon request by Independence Blue Cross and Highmark Blue Shield or by Medicare.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Benefits underwritten or administered by Independence Blue Cross and Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

Your Signature: _____

Today’s Date: - -

FOR OFFICE USE ONLY		
IDENT. No.		
GR NO	TR DT	REAS
BC EFF	PR ST	ORIG
BS EFF	TC	

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: - - Relationship to Applicant: _____

1901 Market Street, Philadelphia PA 19103-1480

Not connected with or endorsed by the U.S. Government or the federal Medicare program.

