Medicare Supplement Coverage Change Form

Please use this form for any of the following changes:

☐ Change in Personal Information - Complete Sections 1 and 3
☐ Change Medicare Supplement Plan - Complete Sections 1, 2a and 3
(*For downgrade only. Complete application is needed for any change requiring underwriting.)
☐ Remove Prescription Drug Coverage - Complete Sections 1, 2b and 3

Premium must be paid for the existing plan up to the effective date of requested coverage change.

1. Personal Information (Please print and use black ink only)

Last Name	First Name			MI
Home Street Address	City	County	State	Zip Code
Billing Address (If different from above)	City		State	Zip Code

☐ Check here if all correspondence should be mailed to the billing address

Phone Number	Social Security Number	Date of Birth
Blue Cross and Blue Shield of Georgia ID Number	Medicare Claim Number	

Is a member of your household enrolled with us in a Medicare Supplement Plan? ☐ Yes ☐ No
If "Yes," you may be eligible for a discount* on your premium. Please provide the following information for that household member.

Name _____ Medicare Claim Number _____

Blue Cross and Blue Shield of Georgia Medicare Supplement Identification Number _____

*See the Outline of Coverage - Premium Information page for details.

2. Coverage Selection

2a. ☐ I would like to change my enrollment to the following Medicare Supplement plan
(Check one only)
☐ Plan A ☐ High Deductible Plan F ☐ Plan G ☐ Plan N

Start Date: _____/ 01 /_____

Generally, the coverage start date will be the first of the month following receipt and processing of this form, unless a later start date is requested above.

2b. ☐ I would like to remove the prescription drug coverage from my current Medicare Supplement plan

Medicare Part D effective date: _____/ 01 /_____

Medicare Part D carrier: *(Optional)* **_____**

This change will coincide with your Medicare Part D enrollment effective date.

We will issue a new policy to you that outline the benefit changes.

3. Certification *(Must be signed and dated to avoid delays in processing)*

I certify that I have read, or had read to me, this completed form. I understand that any untrue answer or statement made within this form may be material to the risk assumed by Blue Cross and Blue Shield of Georgia and may prevent the recovery of benefits under the plan. Such answer or statement may also result in the termination or voiding of the coverage back to its effective date. I understand that any information shown on this coverage change form that differs from what I wrote on my original application shall amend my original application.

I understand that a change in my area of residence may cause a change in my premium. The new premium due to a change in my area of residence will be effective no earlier than the first of the month following the address change.

Signature of Applicant, or Authorized Representative (if applicable)*	Date
X	X

If a legal representative signs on behalf of the applicant, a copy of the legal representative's authority must be provided. This authorization is subject to revocation at any time by written notice to Blue Cross and Blue Shield of Georgia except to the extent that Blue Cross and Blue Shield of Georgia has already taken in reliance on this authorization. Any information received by Blue Cross and Blue Shield of Georgia pursuant to this authorization is subject to restrictions on disclosure to others as set forth under Federal and state laws.

Return this form in the envelope provided or you may fax the completed form to 1-877-270-4084. If the envelope is missing, return the form to the address below.

Blue Cross and Blue Shield of Georgia
P.O. Box 9063
Oxnard, CA 93031-9063

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Blue Cross and Blue Shield of Georgia
PO Box 9063, Oxnard, CA 93031-9063

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Georgia. 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 sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

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 in Medicare Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
_____
☐ Other. (please specify) _____

1. **Note:** If the issuer of the Medicare supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing 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) for similar benefits 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.

_____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

_____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales.

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(Applicant's Signature) (Date)

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