BlueCross BlueShield of Georgia

Blue Cross Blue Shield of Georgia
P.O. Box 659816 • San Antonio, TX 78265-9106

Application for Medicare Supplement and Georgia Extras – Georgia

☐ New Enrollment
☐ Change to Existing Blue Cross Blue Shield of Georgia Medicare Supplement Plan

Send no money now!
For assistance, please contact your Blue Cross Blue Shield of Georgia Insurance Agent or call us at 1-888-211-9817. To be considered for coverage, you must live in the Blue Cross Blue Shield of Georgia service area in Georgia. Please answer all questions fully.

Section A: Applicant Information (Please print and use black ink only.)

Last Name	First Name	MI	Sex ☐ M ☐ F
Home Street Address (Physical Address, not a P.O. Box)			Apt #
City	County	State	ZIP Code
Mailing Address (if different than above)	City	State	ZIP Code
Billing Address (if different than above)	City	State	ZIP Code
Social Security Number ___ ___ ___ | ___ ___ | ___ ___ ___ ___	Date of Birth ___ ___ | ___ ___ | ___ ___ ___ ___	Age	Home Phone Number ( )
Email Address (optional)	Preferred Language Spoken: Written:		

Have you used tobacco products in any form in the past 12 months? ☐ Yes ☐ No

Section B: Medicare Information (From your red, white and blue Medicare card.)

NOTE: The below information is required to complete your enrollment. Enrollment in Original Medicare is required.

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____ MONTH/YEAR

Medical (Part B) Effective Date: _____ MONTH/YEAR

MEDICARE HEALTH INSURANCE
1-800-MEDICARE (1-800-633-4227)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A)
MEDICAL (PART B)

EFFECTIVE DATE
07-01-2010
07-01-2010

Is a member of your household enrolled in or applying for a Medicare Supplement plan with us? ☐ 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 Blue Shield of Georgia Medicare Supplement Identification Number
_____

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

Section C: Plan Chosen (Check only one plan under 1 or 2 below.)

1. **If you are age 65 or over, OR turning 65 in the next 3 months,** the following plan(s) are available to you:
   Medicare Supplement: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N
2. **If you are under age 65 and eligible for Medicare due to a disability,** the following plan(s) are available to you: ☐ Plan A ☐ Plan F ☐ Plan G ☐ Plan N
   If under 65: Describe the health condition that qualified you for Medicare:

   _____

   _____

   Do you have End-Stage Renal Disease (ESRD)? ..... ☐ Yes ☐ No

SilverSneakers® Fitness Program ☐ Yes ☐ No (At no additional cost.)

Section D: Effective Date

Your effective date will be the 1st of the month after we receive your completed Application and it is approved. Upon approval, your effective date cannot be changed. If you provide a future effective date, it cannot be more than 90 days after the date we received your completed application or when first eligible for Original Medicare. **Note:** Effective date of coverage cannot be prior to your Original Medicare effective date.

You can request an initial effective date other than the 1st of the month to ensure continuation of coverage **only** if your existing coverage will terminate on a date other than the end of the month. **Note:** After the initial effective date, your policy will move to a 1st of the month anniversary date.

Requested Effective Date: _____ / _____ / _____
MM DD YYYY

Section E: Billing and Payment Preference

How often do you prefer to be billed? Check one:

☐ Monthly

☐ Automatic Bank Draft*

☐ Quarterly ☐ Annual**

☐ Paper Statement (Mailed to **Billing Address** in Section A)

* For Automatic Bank Draft option, please complete the enclosed Medicare Supplement Premium Payment Form. Automatic Bank Draft is done on the 6th day of the month for your account.

** If you sign up for Automatic Bank Draft and annual payments, you will receive only the annual discount.

Premiums are subject to change on or after the Renewal Date in accordance with the terms of the Policy. Your Premium Billing Preference selection does not guarantee your premium for any specific time period. Renewal Date is defined as generally January 1, subject to state approval.

Section F: Conditions of Application (Answer all questions.)

Please read the six statements below.

Important Statements

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. 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.

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. 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).

General Information

If you lost or are losing other health insurance coverage and received 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, you may be guaranteed issue in one or more of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your Application.

(Please answer all questions by marking "Yes" or "No" with an "X.")

To the best of your knowledge:

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

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

   If yes,

   a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

   b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Yes ☐ No
3. a. If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____ / _____ / _____ END _____ / _____ / _____

   b. If you are still covered under this plan, but know your coverage will end, what is your expected "END" Date. END _____ / _____ / _____

Section F: Conditions of Application *(continued)*

c. If ending, indicate reason why your coverage is ending _____

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

e. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

f. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

4. a. Do you have another Medicare Supplement policy in force? ☐ Yes ☐ No

b. If so, with what company, and what plan do you have?
Company: _____ Plan: _____

c. If so, do you intend to replace your current Medicare Supplement policy with this policy? ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? ☐ Yes ☐ No
(for example, an employer, union or individual plan)

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" blank. …START _____ / _____ / _____ END _____ / _____ / _____

Policy Number _____ Customer Service Phone Number _____

c. If you are still covered under this plan, but know your coverage will end, what is your expected "END" Date.....END _____ / _____ / _____

d. If ending, reason why your coverage is ending _____

6. Have you purchased a stand-alone Prescription Drug Plan (PDP)? ☐ Yes ☐ No

a. If so, with what company?_____

b. PDP Effective Date: _____

Section G: Health History and Medical Provider Information

To determine if you qualify for Guaranteed Issue answer the first three questions. Missing or incomplete responses may cause a delay in processing your application or denial of coverage.

READ CAREFULLY – Please '✓' the box if any of the following apply to you:

☐ You are age **64 1/2 or older and within 6 months before or after your Medicare Part B** coverage effective date;

☐ You are **under age 65** and eligible for Medicare due to a disability **and applying when first eligible**; **OR**

☐ You qualify for Guaranteed Issue coverage for another reason.

Attach proper documentation confirming Guaranteed Issue situation. (Examples include: notice of loss of group coverage and covered under a Medicare Advantage (MA) policy and moving out of the service area.) For a full list of Guaranteed Issue rights, refer to **"Choosing a Medigap Policy:** A Guide to Health Insurance for People with Medicare" available on the Medicare.gov website.

Section G: Health History and Medical Provider Information *(continued)*
(If this section applies to you, answer all questions.)

If you checked any of the above, please skip to the next section. If you did not check any of the above, please answer all questions below completely.

1. Are you currently confined, or has confinement been recommended to a bed, hospital, nursing facility or other care facility, or do you need the assistance of a wheelchair for any daily activity? ☐ Yes ☐ No

2. Within the past two years, have you been hospitalized two or more times, been confined to a nursing home for a total of two weeks or longer, or been to the emergency room more than three times? ☐ Yes ☐ No

3. Within the past two years, have you been advised to have surgery that has not yet been done, or advised that you will need to be admitted to a hospital, skilled nursing facility or rehabilitation facility? ☐ Yes ☐ No

4. Within the past five years, have you been told you had, been consulted for treatment of, sought treatment for, had treatment recommended for, received treatment for, been hospitalized for, or taken or been advised by a physician to take prescription drugs for any of the following conditions:

   a. Heart conditions, **<u>including but not limited to</u>**, heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease, peripheral vascular disease, atrial fibrillation, ventricular tachycardia, transient ischemic attack (TIA) or stroke? ☐ Yes ☐ No

   b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder or other senility disorder? ☐ Yes ☐ No

   c. Any respiratory condition, including but not limited to, chronic obstructive pulmonary disease (COPD) or emphysema (excluding allergies)? ☐ Yes ☐ No

   d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, chronic kidney disease (including end-stage renal disease), kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, any organ transplant (except cornea), ALS (Lou Gehrig's disease), amputation or joint replacement due to disease? ☐ Yes ☐ No

   e. Sought medical treatment or consultation for bipolar illness, major depression, schizophrenia, psychosis, alcoholism or drug abuse? ☐ Yes ☐ No

5. Have you ever been diagnosed as having acquired immune deficiency syndrome (AIDS) or AIDS-related complex (ARC)? ☐ Yes ☐ No

6. Are you taking any prescription medications? ☐ Yes ☐ No

7. In the past year, have you visited the same medical provider for 8 or more consecutive months for medical advice or treatment for the same condition? ☐ Yes ☐ No

Section G: Health History and Medical Provider Information *(continued)*
For each question you answered "YES" above, please provide complete details below.
(See the example as a guideline). If additional space is needed, attach a separate sheet.

Item #	Specific illness, injury, procedure, surgery, hospitalization or condition	Name of Medication and Dates of Use	Provider Name, Address, Telephone (with area code),and Fax for Doctor	Dates of illness, injury, procedure, surgery, hospitalization or condition	
				Begin	End/ Current
Note: This row is an example of how to complete this section. Please begin with next row.					
4a	*Congestive Heart Failure*	*Lanoxin* *1/2001* *7/2005*	*Dr. John Doe 10 High Street, Suite 45 Anywhere, US 19222 1-555-555-1000 (phone) 1-800-555-2000 (fax)*	*11/1999*	*7/2005*

Name of Primary Care Physician _____

Address _____

Phone (_____) _____ FAX (_____) _____

Section H: Georgia Extras Packages (Additional Premiums Apply)

To be eligible for this coverage, you must be at least 65 years of age or older when the policy becomes effective.

These optional benefits are available to you at an **additional premium** and are not part of the Medicare Supplement Plans that we offer. If you enroll in Georgia Extras, you will receive separate documentation, identification card and bills related to your enrollment in Georgia Extras.

If you currently have medical or dental coverage through Blue Cross Blue Shield of Georgia, please provide your Identification Number: _____

If you are still covered under this plan, leave "END" blank. START ___ / ___ / ___ END ___ / ___ / ___

If you are a current Blue Cross Blue Shield of Georgia member, what insurance do you have with us?

☐ Individual Health ☐ Individual Dental
☐ Group Health ☐ Group Dental ☐ Group Vision

The **effective date** will be the same as the effective date on page 2 of the Medicare Supplement Application.

Section H: Georgia Extras Packages (Additional Premiums Apply) *(continued)*

Georgia Extras Offerings:

☐ Standard Package ☐ Premium Plus Package

☐ Premium Package ☐ Premium Plus Dental (**only**)

Billing/Payment options:

Select One: ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Select One: ☐ Paper Statement (mailed to **Billing Address** in Section A)

☐ Automatic Bank Draft (Premium deducted same day as your effective date – Georgia Extras Premium Payment Form required)

Section I: Authorizations and Agreements

I, the applicant or my authorized representative, certify that I or my authorized representative have read, or had read to the applicant, the completed Application, and understand this Application in its entirety and have personally completed this Application.

I, the applicant or my authorized representative, acknowledge **any false statement or misrepresentation on the Application may result in loss of coverage under the policy** and that it is my/our responsibility for accurately completing this Application. I understand that I am not eligible for any benefits if any information requested on this Application, even information about my Medicare coverage, is false, incomplete or omitted. I understand that the Company may void all coverage from the original effective date of the policy, to the extent of material misrepresentation only in the event that I failed to accurately respond to questions on this Application. In addition, I understand that I am responsible for notifying Blue Cross Blue Shield of Georgia of any changes to information on this application or new information that is discovered after the submission of my Application but before my coverage becomes effective, including changes in my medical condition if not eligible for Guaranteed Issue.

I understand and agree to the Conditions of Application and the Authorization and Agreements in this Application. If applicable, I also understand and agree to the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage (Replacement Notice) provided with this Application. If my Application is accepted, it will become part of the agreement between the Company and myself.

I, the applicant or my authorized representative, acknowledge receipt of:

- Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare*, and
- the *Outline of Coverage*.

I, the applicant or my authorized representative, understand that the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy or terms of any Company coverage.

I, the applicant, am currently enrolled in an Blue Cross Blue Shield of Georgia health policy/ certificate and wish to cancel that policy when this Medicare Supplement Application is approved and I become enrolled.

Blue Cross Blue Shield of Georgia Identification Number:

_____

Section I: Authorizations and Agreements *(continued)*

I, the applicant or my authorized representative, acknowledge responsibility for any overdraft fees permitted by state law.

I, the applicant or my authorized representative, understand that there is a six-month benefit waiting period for coverage of any condition for which I received medical treatment or advice within the six months prior to the effective date of this Medicare Supplement policy. I understand that the time I was covered under any other health insurance will be counted toward this 6-month benefit waiting period, if there is not a break in coverage greater than 63 days between the termination of the other coverage and the effective date of this Medicare Supplement policy.

I, the applicant or my authorized representative, understand that if I incur an illness or change in medical condition during the time between the date I sign this application and the effective date of coverage, I must notify Blue Cross Blue Shield of Georgia in writing of any such illness or change, and such notice shall be a condition of my coverage. (This does not apply if I am applying during my open enrollment period or qualify for guaranteed issue coverage for another reason.)

I, the applicant or my authorized representative, understand that Blue Cross Blue Shield of Georgia may convert my payment by check to an electronic Automated Clearinghouse (ACH) debit transaction. The debit transaction will appear on my bank statement although my check will not be presented to my financial institution or returned to me. This ACH debit transaction will not enroll me in any Blue Cross Blue Shield of Georgia automatic debit process and will only occur each time I send a check to Blue Cross Blue Shield of Georgia. Any resubmissions due to insufficient funds may also occur electronically. I understand that all checking transactions will remain secure and my payment by check constitutes acceptance of these terms.

I understand that Blue Cross Blue Shield of Georgia may need to collect personal information about me from outside sources in order to approve my Medicare Supplement Application. Personal and privileged information may only be disclosed to outside parties without my authorization if such disclosure is permitted by both the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations (45 C.F.R. Parts 160 and 164) and state law. I also understand that under the HIPAA Privacy Regulations and state law, I have a right to see and correct personal information that Blue Cross Blue Shield of Georgia collects about me, and that I may receive a more detailed description of my rights under these laws by writing to Blue Cross Blue Shield of Georgia.

I hereby authorize, at the request of Blue Cross Blue Shield of Georgia, any medical professional, hospital, clinic or other medical or medically related facility, government agency or other medical person or firm, to disclose information, including copies of records concerning advice, care or treatment provided to me in order for Blue Cross Blue Shield of Georgia to review and evaluate my Medicare Supplement Application. This authorization does not extend to the disclosure of a provider's notes taken during psychotherapy sessions that are maintained separately from the provider's other medical records. This authorization will expire upon completion of the Application process. I understand that I may revoke this authorization at any time by giving written notice of my revocation to: Blue Cross Blue Shield of Georgia, P.O. Box 659816, San Antonio, TX 78265-9106. I understand that revocation of this authorization will not affect any action taken in reliance on this authorization before you received my written notice of revocation.

Section J: Policy Issuance

Important: This Application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in the Application.

Please do not cancel your present coverage, if any, until you receive documentation from Blue Cross Blue Shield of Georgia, such as an ID card or written notification, showing that your Application has been approved.

To ensure timely processing, verify the following:

1) Complete, sign and date all sections as indicated by signature boxes.

2) If you want the convenience of automatic bank draft for payment purposes, be sure to complete the **Premium Payment Form.**

3) If replacing other coverage, the Replacement Notice is signed and dated by both you and your insurance agent (if applicable) and returned with your Application.

Please mail the entire Application (including any additional forms) to the address below:

Blue Cross Blue Shield of Georgia
P.O. Box 659816
San Antonio, TX 78265-9106
OR – Fax to: 1-844-236-7967

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

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to Application (such as a Power of Attorney).

SEND NO MONEY NOW – PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED AND YOU RECEIVE YOUR PREMIUM NOTICE.

Section K: Agent/Broker Information Only:

If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

Important: Before this form can be processed, the agent/broker's current health and life license must be on file. In addition, the agent/broker must be appointed with us.

Agent/Broker No.: _____

Agency No.: _____

(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name: _____

Phone No. (_____)_____

Fax No. (_____)_____

Street Address _____

City_____ State_____ ZIP Code_____

Email Address: _____

Section K: Agent/Broker Information Only: ***(continued)*** If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

Attestation - Please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this Application by phone, e-mail or in person.

☐ I certify that the applicant has read, or I have read to the applicant, the completed Application. To the best of my knowledge, the information on this Application is complete and accurate. I explained to the applicant, in easy to understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I certify that the applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

Have you sold any other health insurance policies to the applicant in the last five years, either in force or not? ☐ Yes ☐ No

If yes, list all health insurance policies sold:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

I have read and understand the Application. I certify that I have given the applicant the *Guide to Health Insurance for People with Medicare* and the *Outline of Coverage* for the policy applied for, and that the applicant has both Medicare Part A and Part B. The policy applied for will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the policy applied for will not duplicate any coverage. I have verified the information in the Replacement Notice section.

Agent/Broker's Signature: **X** _____ **Date of Signature:** _____

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

Blue Cross Blue Shield of Georgia
P.O. Box 659816, San Antonio, TX 78265-9106

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Blue Cross 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 (pre-existing 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 pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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

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

Blue Cross Blue Shield of Georgia
P.O. Box 659816, San Antonio, TX 78265-9106

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Blue Cross 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 (pre-existing 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 pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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

Blue Cross and Blue Shield of Georgia
P.O. Box 659816
San Antonio, TX 78265-9106
Fax: 1-844-236-7967

BlueCross BlueShield of Georgia

Premium Payment Form for Medicare Supplement and Georgia Extras Packages

With Automatic Bank Draft, Blue Cross and Blue Shield of Georgia (BCBSGa) will automatically draft your premium directly from your checking account.

Full Name (please print)		Phone	
Home Street Address (Physical Address, not a P.O. Box)		Apt #	
City	County	State	ZIP Code
Mailing Address (if different than above)	City	State	ZIP Code
Billing Address (if different than above)	City	State	ZIP Code

Medicare Supplement

Simplify Your Life! It saves you valuable time and money.

Pay annually and save $48 or sign up for monthly Automatic Bank Draft and save $2 per month ... it is easy to sign up!

(Available on Medicare Supplement policies with an effective date on or after June 1, 2010.)

☐ EXISTING MEMBER (Changing Medicare Supplement Payment Option to Automatic Bank Draft)

Medicare Supplement Identification Number (as shown on Medicare Supplement ID card): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set up Automatic Bank Draft for your premiums.) Please return this form to: Blue Cross and Blue Shield of Georgia, P.O. Box 659816, San Antonio, TX 78265-9106.

☐ NEW APPLICANT (Initial Submission of a Medicare Supplement Application)

I understand that the premium for the coverage I have selected is $_____.*

If your application is accepted and the amount you indicated is less or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you. **To ensure proper payment setup, this form MUST be returned with your Application.*

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your Premium Billing Preference selection does not guarantee your Premium for any specific time period. The policy renewal date is defined as generally January 1, subject to state approval. Please refer to your *Outline of Coverage* for additional information regarding changes in Premiums.

BILLING FREQUENCY PREFERENCE (For Existing Medicare Supplement Member and New Applicant)

Deduct Premium: ☐ Monthly

Quarterly and Annual Premium Billing Preferences are only available by paper billing statement as shown in the Billing Preference section in the Application.

Georgia Extras Packages

☐ EXISTING MEMBER (Changing Georgia Extras Packages Payment Option to Automatic Bank Draft)

Georgia Extras Identification Number (as shown on Georgia Extras ID card): _____

Billing number (starting with SR): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set up Automatic Bank Draft for your premiums.)

☐ NEW APPLICANT (Initial Submission of a Georgia Extras Packages Application)

I understand that the premium for the coverage I have selected is $_____.*

If your application is accepted and the amount you indicated is less or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you. ***To ensure proper payment setup, this form MUST be returned with your Application.*

BILLING FREQUENCY PREFERENCE (For Existing Georgia Extras Member and New Applicant)

Frequency (select one): ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Banking Information For Any Medicare Supplement and Georgia Extras Packages Selected Above

BANK INFORMATION (For Existing Member and New Applicant)

Deduct Premium From: ☐ Checking Account **Start Date:** _____/____/_____

Is this a business account: ☐ Yes ☐ No

Account Holder Name(s):

Name of Financial Institution:

Bank Routing/Transit Number (9 digits)	Bank Account Number
_____ _____ _____ _____ _____ _____ _____ _____ _____	_____

(continued)

Automatic Bank Draft Payment: I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium(s), and the designated financial institution named above to debit the same account.

I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Blue Cross and Blue Shield of Georgia when set up, I authorize my bank to draft both the past due premium along with current premium(s) to ensure my coverage stays in effect. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception**: In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Blue Cross and Blue Shield of Georgia and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction and that I will not receive a bill.

Return this authorization as indicated above. **No service fees apply when paying by Automatic Bank Draft.**

Account Holder's Signature (as it appears on your bank account)	**Date**

Refer to the image below to identify where to locate the Routing Number and Bank Account Number. Do not include the check number as part of the Routing or Account Number.