Medi-Pak Application

Before completing this application, please read the following instructions:

- This application is a legal document. If you are approved for coverage, it will become part of your contract. Therefore, it is very important that you provide **all** requested information and that it is accurate and legible.
- Some people have guaranteed rights into some Medicare supplement plans. If this applies to you, you are **not** required to complete the health questions (Sections 12, 13, or 14) or the Authorization to Disclose Protected Health Information (next page). If you do not have these guaranteed rights, please make sure you complete the health questions and the Authorization form.
- This application must be completed in dark blue or black ink. **No pencil please.**
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- **Do not use liquid paper, correction tape or "white out" to correct any mistakes you make on this application.**
- Any attached sheets must be signed and dated.
- Please ensure that you sign and date the application.
- Please do **not** send money with this application.
- **We strongly encourage you to make a photocopy of this completed application for your records.**

Policy Effective Dates:

The policy will become effective on the 1st of the month. Once your application is approved, we will attempt to contact you to find out what effective date you would like. Rules for effective dates are:

- You **cannot** have an effective date prior to your Medicare Part A and Part B effective dates.
- You **cannot** have an effective date prior to your termination from a Medicare Advantage plan.
- You **cannot** have an effective date prior to your application submit date.

What Is Open Enrollment?

State and federal laws guarantee that for a period of six months from the date you are both enrolled in Medicare Part B and are age 65 or older, you have a right to buy the Medicare supplement policy of your choice, regardless of any health problems you may have. Your open enrollment period begins with the first day of your birth month and continues for six months. If your birthday falls on the first day of the month, your Medicare coverage will begin the first day of the previous month, while you are age 64. Your open enrollment period will also begin at that time.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices.

I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72201. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 et seq., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 et seq. and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 et seq. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization includes authorization to release information on the diagnosis and treatment of mental illness, alcohol, and drug use, as well as authorization to release information on the diagnosis, treatment, and testing results related to HIV-AIDS, and sexually transmitted diseases, unless otherwise restricted by applicable law.

Please note the following consequences if you decline to sign this authorization for release of your medical information, or if you later revoke it: in that event, we may be unable to process your application or evaluate a claim for coverage and would then deny your application or your claim for policy benefits.

This authorization must be signed by the proposed insured.

Proposed Insured's Name (print)	**Signature**	**Date**

Section 1 | Who is applying

First name	Middle initial	Last name

Suffix	Sex	Date of birth	Social Security No.

Section 2 | Contact information*

Primary phone number	Alternate phone number	Best Time to Call
		☐ A.M. ☐ P.M.

Email Address

How do you prefer we communicate with you? ☐ Phone ☐ Email

*Arkansas Blue Cross and Blue Shield may contact you, either directly or through a business associate, using your postal or email addresses, telephone numbers or other personal information, regarding your health insurance plan, healthcare providers participating in our networks, disease management, health education and health promotion, preventive care options, wellness programs, treatment or care coordination or case management activities of Arkansas Blue Cross.

Section 3 | Residential street

Residential street or P.O. Box	City	State	County	ZIP
		AR		

Section 4 | Mailing address (complete only if different than residential address)

Mailing street or P.O. Box	City	State	County	ZIP

Section 5 | Billing address (complete only if different than residential address)

Billing street or P.O. Box	City	State	County	ZIP

Section 6 | Medi-pak plan (choose one)

☐ **A** ☐ **B*** ☐ **C** ☐ **F** ☐ **F High Deductible** ☐ **G** ☐ **N**

*Plan designed for Medicare-disabled individuals not yet age 65

Section 7 | Requested effective date

What would you like your effective date to be? (**Note:** Changes can only become effective on the 1st of the month.)

Month	Day	Year
	01	

Section 8 | Billing mode (check one only)

How do you want to be billed? ☐ Monthly Bank Draft ☐ Monthly Invoice

Section 9 | Current Blue Cross coverage

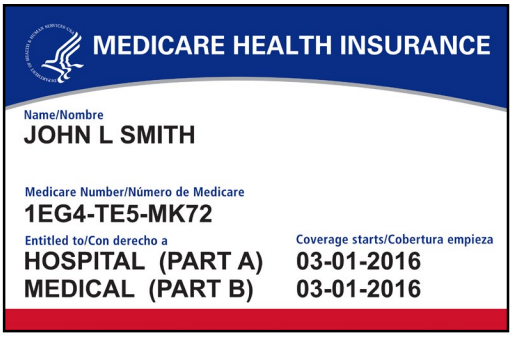
Do you now have Blue Cross and Blue Shield Coverage? ☐ Yes ☐ No

Your Blue Cross I.D. No.:	City/State of Blue Cross Plan:

Section 10 | Please provide your Medicare Insurance Information

Please fill in these blanks so they match your red, white and blue Medicare card. You must have both Medicare Hospital (Part A) and Medicare (Part B) coverage to apply for Medi-Pak.

Medicare Number:			
Hospital (Part A) Coverage starts:	**Month**	**Day**	**Year**
Medical (Part B) Coverage starts:	**Month**	**Day**	**Year**



For Office Use Only (Do not write in this space)

☐ Approved ☐ Denied

Date	ICU

I.D.#	Group #	Effective date	PKG

Home office endorsements:

Section 11 | Eligibility questions

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 acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application.

Please mark Yes or No below with an "X" ---- To the best of your knowledge:

1. ☐ Yes ☐ No 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?

c. If you answered **Yes** to 1b, what is the effective date? _____/_____/_____

2. ☐ Yes ☐ No 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.

If you answered **No** to 2, please go to 3a.

If you answered **Yes** to 2, please answer 2a and 2b.

☐ Yes ☐ No 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?

3. ☐ Yes ☐ No a. Have you had coverage from a **Medicare Advantage** (HMO, PPO or PFFS) plan within the past 63 days?

If you answered **No** to 3a, please go to 4a.

If you answered **Yes** to 3a, please fill in your start and end dates below.

Start _____/_____/_____ End _____/_____/_____

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

☐ Yes ☐ No c. Was this your first time in this type of **Medicare Advantage** plan?

☐ Yes ☐ No d. Did you drop a **Medicare supplement** policy to enroll in the **Medicare Advantage** plan?

☐ Yes ☐ No e. Did you move out of the service area of your **Medicare Advantage** plan?

☐ Yes ☐ No f. Did your **Medicare Advantage** plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guaranteed issue into a Medigap policy?

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

If you answered **No** to 4a, please go to 5.

If you answered **Yes** to 4a, please answer 4b and 4c.

b. If so, with what company, and what plan do you have?

_____

☐ Yes ☐ No c. If so, do you plan to replace your current **Medicare supplement** policy with this policy?

5. ☐ Yes ☐ No Have you had health insurance coverage under an **employer/group or union** (including COBRA), or **Blue Cross Individual plan** within the past 63 days?

If you answered **Yes** to 3 or 4, please answer **No** to 5.

If you answered **Yes** to 5, please answer 5a and 5b.

a. If so, with what company and what kind of policy?

b. What are your dates of coverage under the other policy? Please fill in your start and end dates below.

Start _____/_____/_____ End _____/_____/_____

STOP

During your Medicare Supplement Open Enrollment (see cover page for "What is Open Enrollment?"), you are not required to complete the health questions (Sections 12, 13 or 14) or the Authorization To Disclose Protected Health Information (located after cover page). If you are in your Medicare Supplement Open Enrollment, please skip to Section 15.

If you are NOT in your Medicare Supplement Open Enrollment, please answer ALL of the following health questions. Acceptance or rejection of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage and our review of your answers to the medical questions. Applications cannot be processed unless all questions are answered.

Section 12 | Medical questionnaire

For each question checked below, give full details in the **ADDITIONAL MEDICAL INFORMATION** section which follows.

In the last 10 years, have you been told you had:

(Each section must have at least one box checked.)

A. Brain or nervous system disorders

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Convulsions, epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above**

B. Respiratory

- ☐ Chronic obstructive pulmonary disease or asthma
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea (CPAP)
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above**

(Each section must have at least one box checked.)

C. Digestive

- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Ulcerative colitis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above**

D. EAR/Eyes/Nose/Throat

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above**

E. Circulatory

- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above**

F. Cancers, Lymphatic System, Blood or Skin Disorders

- ☐ Anemia
- ☐ Cancer
- ☐ Hodgkin's disease
- ☐ Leukemia
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above**

G. Glandular Disorders

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- ☐ **None of the above**

H. Musculoskeletal

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Fibromyalgia
- ☐ Lupus, systemic
- ☐ Any other disorder of the muscles, bones or joints
- ☐ **None of the above**

(Each section must have at least one box checked.)

I. Kidney, Urinary, Reproductive

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ **None of the above**

J. Mental/Emotional or Substance Abuse

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ **None of the above**

K. Other

- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient (except Corneal)
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above**

Additional medical information

Give full details to conditions checked for questions A thru K.

- Under "Specific Condition/Illness and Type of Treatment" below, in addition to condition/illness, please provide the type of treatment provided or planned. For example:
  - Surgery
  - Hospitalization
  - Emergency room visit
  - Chiropractic treatments
  - Nursing Home confinement
  - Doctor visits
  - Rehabilitation therapy — (e.g. speech, physical, occupational)
- Please ensure you include **all** the treatments that apply.
- **Please indicate the name(s) that would have been given at the time of the physician visit — e.g., a maiden name.**

Question Number(s)	Condition/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	
H	Specific Condition/ Illness: **Arthritis** Type of Treatment: **Doctor Visit**	**01** mo / **05** year	**07** mo / **09** year	**20**		**X**		Dr. Jones 123 Main Street Anytown, AR 72221

Question Number(s)	Condition/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	
	Specific Condition/ Illness: Type of Treatment:	___/___ mo year	___/___ mo year		☐	☐	☐	
	Specific Condition/ Illness: Type of Treatment:	___/___ mo year	___/___ mo year		☐	☐	☐	
	Specific Condition/ Illness: Type of Treatment:	___/___ mo year	___/___ mo year		☐	☐	☐	
	Specific Condition/ Illness: Type of Treatment:	___/___ mo year	___/___ mo year		☐	☐	☐	
	Specific Condition/ Illness: Type of Treatment:	___/___ mo year	___/___ mo year		☐	☐	☐	
	Specific Condition/ Illness: Type of Treatment:	___/___ mo year	___/___ mo year		☐	☐	☐	

1. Height ____________________ Weight ____________________

2. ☐ Yes ☐ No Are you Medicare Disabled? If **Yes**, please indicate disability condition(s):

____

____

____

3. ☐ Yes ☐ No Have you ever been declined or rated for the issuance of life, accident, health or long-term care insurance? If **Yes**, please explain:

4. ☐ Yes ☐ No Have you used any form of tobacco within the last 12 months? If **Yes**, please indicate:

Type of tobacco _____

Amount _____

5. In the last 10 years, have you:

☐ Yes ☐ No a. chronically or habitually used an alcoholic beverage(s) to the extent that your normal faculties are impaired; and/or been voluntarily or involuntarily committed to an alcohol abuse treatment facility; and/or been convicted of (2) or more offenses related to the use of alcohol; and/or been found to have blood alcohol concentrations of 0.08% (federal presumptive level of intoxication for driving) or greater? If **Yes**, please explain:

☐ Yes ☐ No b. used any addictive or non-addictive drug or substance except as provided by a physician? If **Yes**, please explain:

☐ Yes ☐ No c. had unexplained or unintentional weight loss of 10 pounds or more? If **Yes**, please explain:

☐ Yes ☐ No d. required the assistance of any other individual for performances of any activities of daily living? If **Yes**, please check all that apply:

☐ **Bathing** ☐ **Dressing** ☐ **Transferring**
☐ **Eating** ☐ **Toileting** ☐ **Continence**

Section 13 | Primary physician information

Complete Name and Address of Physician	**Date of Last Visit***
	_____/_____/_______ mm / dd / yyyy

Reason for Visit

☐ No visit ☐ New patient ☐ Check-up ☐ Referral/Specialist ☐ Other

Section 14 | Prescription questionnaire

☐ Yes ☐ No Are you currently taking any prescription medication, or have you taken prescription medication in the **last 3 years?**

If you answered Yes, please provide full details below. A print out from the pharmacy is **not** acceptable.

Name of Drug	Dosage	Specific Condition or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Physician
				None	Partial	Full	
			____/____ mo year ____/____ mo year	☐	☐	☐	
			____/____ mo year ____/____ mo year	☐	☐	☐	
			____/____ mo year ____/____ mo year	☐	☐	☐	
			____/____ mo year ____/____ mo year	☐	☐	☐	
			____/____ mo year ____/____ mo year	☐	☐	☐	
			____/____ mo year ____/____ mo year	☐	☐	☐	
			____/____ mo year ____/____ mo year	☐	☐	☐	

Section 15 | Important: please read and sign

Send no money with this application. You will be billed.

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 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).

In signing below, I represent that the statements and answers given in this application and any signed and dated addendum to this application are true, complete and correctly recorded. I authorize and release to Arkansas Blue Cross and Blue Shield Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits. I (a) agree that this authorization shall be valid without time limit; (b) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

X _____ _____

Sign Here (must be signed and dated by proposed insured) Date

This Section to be completed by Sales Representative

List any other health insurance policies you have sold to this applicant.

1. List policies sold which are still in force. _____
2. List policies sold in the past five (5) years which are no longer in force. _____

Sales Rep NPN # (required)	**Sales Representative's Name** (Please Print)	**Telephone No.**
Agency Federal Tax ID # (If applicable)	**Sales Representative's Signature** X	**Date Signed**

COMMENTS:

Pre-authorized bank draft | Monthly program sign-up form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Insured's information

First name	Last name

Street address	Apt. no.	City	State	ZIP

Bank account information

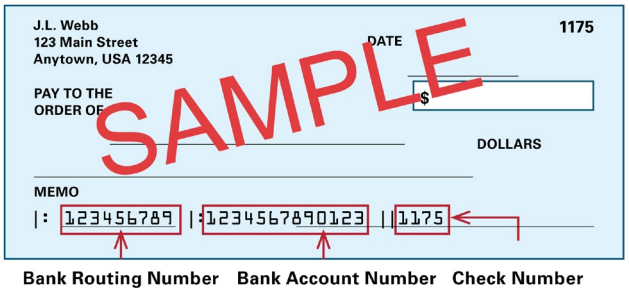
Bank name

Name on account (If different than the proposed insured)

Routing number	Account number

Type of account

☐ Checking ☐ Savings



Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated above, to debit my Arkansas Blue Cross premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next

Pre-Authorized Bank Draft Program withdrawal date.I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Signature

Signature of bank account holder	Date

Arkansas BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association

For office use only (please do not write in this space)

ID No.	Effective date

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.