Highmark Blue Cross Blue Shield Delaware
Attn: Underwriting Services (1-8-10)
P.O. Box 1991
Wilmington, DE 19899-1991

MEDICARE SUPPLEMENT APPLICATION

PART I. GENERAL INFORMATION

APPLICATION INFORMATION

Print Name: First Middle Last

Address: Street City State DE Zip Code

Mailing Address: (If different) Street City State DE Zip Code

Birth Date: / / Current Age: Social Security Number: – – Gender: ☐ Male ☐ Female

Telephone Number: ( ) Email Address:

I am: ☐ retired or ☐ working hours per week. Name of employer:

My spouse is: ☐ retired or ☐ working hours per week. Name of employer:

REASON FOR APPLICATION Check most appropriate box.

☐ I am a new customer and this is my first Medicare Supplement Plan.

☐ I am a new customer but have a Medicare Supplement Plan with another carrier.
Reason for changing carriers: ____________________

☐ I am currently enrolled in a Highmark DE Individual policy. ID #____________

☐ I am currently enrolled with group coverage through my or my spouse's employer. If Highmark DE member, provide ID # ____________
Reason for change in coverage: ____________________

☐ I am applying to have my policy reinstated. ID #____________

MEDICARE INFORMATION

To apply for a Medicare Supplement policy with Highmark DE, you must meet the criteria below as of the date your policy will begin: 1) a Delaware resident 2) enrolled in and maintain Medicare A and B.

Please provide your Medicare information below as shown on your red, white and blue card.

Medicare Claim Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date

Select a Plan: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan F High Deductible

Select an Effective Date: 1st of ____________ (specify month)

PART II. HEALTH QUESTIONS

1. By the effective date of this policy, will you be age 65 or older? ☐ Yes ☐ No
2. By the effective date of this policy, will you have been enrolled in Medicare Part B for six or less months? ☐ Yes ☐ No
3. Have you used any form of tobacco in the last 12 months? ☐ Yes ☐ No

If the answer to questions 1 and 2 above is "Yes" and you meet the eligibility criteria in the Medicare Information section, please skip to Part III. You do not need to answer the questions in the Statement of Health section on page 2.

For GA/Broker Use Only	Broker Name/Number	GA Name/Number

BROKER: Please complete questions at the end of page 4.

ENR-182 (R4-13)

STATEMENT OF HEALTH

Current Height : _______ feet ______ inches Current Weight: _______ pounds

1. Are you currently bedridden, hospitalized, or residing in a nursing home, convalescent or assisted living facility? .... ☐ Yes ☐ No
2. Has your physician advised you to have surgery, therapy, tests or treatment in the past two years which you have not had? .... ☐ Yes ☐ No
3. Do you need supervision, assistance or a wheelchair for any activities of daily living, such as eating, dressing, bathing or walking? .... ☐ Yes ☐ No

If the answer to questions 1, 2 or 3 above is "Yes", please explain: ________________________________

4. Have you been diagnosed or treated for any of the following conditions in the last five years? Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling.

a. AIDS, HIV or other immune diseases	☐ Yes ☐ No	i. Heart attack, heart disease	☐ Yes ☐ No
b. Alcohol or Substance abuse	☐ Yes ☐ No	j. Joint Replacement	☐ Yes ☐ No
c. Alzheimer's or dementia	☐ Yes ☐ No	k. Kidney disease, dialysis, renal failure	☐ Yes ☐ No
d. Arthritis - disabling	☐ Yes ☐ No	l. Liver (chronic) disorder, cirrhosis, hepatitis C	☐ Yes ☐ No
e. Bone Marrow or other major organ transplant	☐ Yes ☐ No	m. Parkinson's, Multiple Sclerosis, ALS (Lou Gehrig's disease), Systemic Lupus, Muscular Dystrophy	☐ Yes ☐ No
f. Cancer (exclude basal, squamous cell)	☐ Yes ☐ No	n. Psychiatric illness or history requiring hospitalization	☐ Yes ☐ No
g. Diabetes (using insulin)	☐ Yes ☐ No		
h. Emphysema, COPD or lung disorder	☐ Yes ☐ No	o. Stroke or paralysis	☐ Yes ☐ No

4b. If you answered " Yes," to any question above, please provide requested information below:

Corresponding Letter of Condition Listed Above	Date Condition Started	Date of Last Treatment	Describe Results / Findings / Status	Full Name of Treating Physician

5. In the last 12 months, have you taken or been prescribed any prescription medications? .... ☐ Yes ☐ No

5b. If you answered "Yes," please provide details below. Please list additional medications on a separate sheet.

Medication	Are You Still Taking This Medication?	Dosage	Frequency	Condition for which prescribed
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

PART III. EXISTING COVERAGE 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 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 our prior insurer with your application. Please answer all questions.** If the response to the question is "**No**," proceed to the next question. If the response is "**Yes**," reply to the additional questions.

1. Do you have another Medicare Supplement policy in force? .... ☐ Yes ☐ No
   - If yes, with what company and what plan do you have?________________________________
   - If yes, do you plan to replace your current Medicare supplement policy with this policy? .... ☐ Yes ☐ No

2. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g., a Medicare Advantage plan, or a Medicare HMO or PPO)? ☐ Yes ☐ No
   - If yes, provide the Start Date ____/____/____ and End Date ____/____/____ (leave blank if still covered)
   - If you are still covered under this Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ Yes ☐ No
   - Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   - Did you drop a Medicare Supplement policy to enroll in this Medicare plan? ☐ Yes ☐ No
3. Have you had coverage under any other health insurance plan within the past 63 days (e.g., an employer, union, or individual plan)? ☐ Yes ☐ No
   - If yes, what kind of policy?____
   - What are your dates of coverage under the other policy? Start Date ____/____/____ End Date ____/____/___ (leave blank if still covered)
4. 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, will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No
   - If yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Yes ☐ No

PART IV. PAYMENT

With this application, please include payment for premiums. Please select one of the billing options below:

Check or Money Order. Enclose a check or money order made payable to Highmark Blue Cross Blue Shield Delaware.

Select a Billing Option: ☐ Monthly ☐ Quarterly

PART V. CUSTOMER INFORMATION

- 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 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services are available in Delaware 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). Call **ELDERinfo** at 800.336.9500 or 302.674.7364.
- 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

PART VI. TERMS OF AGREEMENT (PLEASE READ CAREFULLY, THEN SIGN.)

I understand and agree that:

1. I am eligible for coverage only if I have both Parts A and B of Medicare, am a Delaware resident, and am not eligible for coverage in a Highmark DE group.
2. Once I have paid my premium, my coverage begins on the first day of the month after this application is approved and accepted. My coverage can only be cancelled if I do any of the following:
   - request cancellation in writing,
   - fail to pay my premium,
   - knowingly misrepresent or furnish inaccurate information on this application, or
   - fail to keep Parts A and B of Medicare.
3. There is a six-month waiting period before benefits are paid for any preexisting condition I may have; however, I understand I may have the ability to reduce or eliminate this waiting period. I will be credited for the time I have been continuously covered if I am:
   - applying for a change in my current Highmark DE plan; or
   - replacing another company's or another Blue Cross and Blue Shield Plan's coverage.

   In that case, I must provide a Certificate of Coverage from this carrier.

   I understand that a preexisting condition is any disease, condition or ailment for which I was treated or for which I received medical advice during the six months before the date my coverage begins with Highmark DE.
4. I authorize any medical professional, hospital, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medically-related facility, governmental agency or other person or firm, to disclose to Highmark DE or Highmark DE's authorized representative, information (including copies of records) concerning advice, care or treatment provided to me. That information may include, without limitation, information relating HIV/AIDS, mental health, or abuse of drugs or alcohol. In addition, I authorize Highmark DE to use its own records for information. I understand that such information will be used by Highmark DE to evaluate my application for health coverage, to decide whether or not to offer me coverage, and to determine whether I am eligible for benefits. I understand information obtained with my authorization may be re-disclosed by Highmark DE as permitted or required by law and that upon such re-disclosure, it may no longer be protected by federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid for two years from the date signed unless (a) revoked by me in writing, which I may do at any time, or (b) Highmark DE declines this application. Any revocation will not affect the activities of Highmark DE prior to the date such revocation is received by Highmark DE.
5. All the information I have given on this application is true and complete to the best of my knowledge and belief. If the information is false, my coverage is void.

Signature ____ **Date** _____ / ______ / ______

PART VII. INSTRUCTIONS

BEFORE MAILING PLEASE BE SURE THAT THE FOLLOWING HAS BEEN COMPLETED:

- Answer all questions on this application (incomplete applications will be returned)
- Sign and date the application
- Include payment
- Submit a Certificate of Coverage to reduce the preexisting waiting period if you had prior coverage with another carrier (excluding Highmark DE and Medicare)
- Call the Highmark DE Marketing Department at 888.692.5830 if you have any questions about completing this application

Important Note: As of January 1, 2012, the definition of spouse includes a civil union partner.

Thank you for selecting Highmark DE as your Medicare Supplement carrier. We look forward to serving you!

For Broker Use Only:

1) List policies sold to applicant that are still in force:

Name of Insurer	Type of Policy

2) List policies sold to applicant in the past five years that are no longer in force:

Name of Insurer	Type of Policy

Highmark Blue Cross Blue Shield Delaware is an independent licensee of the Blue Cross and Blue Shield Association