



South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

www.SouthCarolinaBlues.com

P.O. Box 100133 • Columbia, SC 29202-3133

MEDICARE SUPPLEMENT APPLICATION

Tell Us About Yourself (Please Print. Answer All Questions).

Male Female Birthdate / / Name Email Address Address City State Zip Home Phone Number Social Security Number Please enter your Medicare number, which is on your Medicare card:

Which Plan Are You Applying For?

Please fill in the Plan for which you are applying.

Medicare Supplement Plan

Billing Information

How do you wish to be billed? Monthly Bank Draft* Monthly Billing Quarterly Billing

*If you choose Monthly Bank Draft, complete the authorization agreement on the back of this form and attach a voided check along with your first premium. Please note: if the effective date is the 1st, the draft will be on or after the 3rd of each month and if the effective date is the 15th, the draft will be on or after the 15th of each month.

Requested Effective Date: 1st 15th Please Note: Current South Carolina Blue Cross Medigap customers will be assigned an effective date that is consistent with their current coverage.

Health Information

Are you within the Open Enrollment period? Yes No Open Enrollment begins on the first day you are at least age 65 and enrolled in Medicare Part B and continues for six months.

Date of enrollment in Medicare Part A: / / Date of enrollment in Medicare Part B: / /

If you answered yes to the above question, you do not need to answer the following health questions, and the pre-existing condition limitation on the back of this application is waived except for hospital stays that commenced before the effective date of this policy.

Have you had medical or surgical advice, treatment or consultation for any of the conditions in A, B, or C below in the past five years? Also, please answer questions D, E and F below.

- A. Yes No Cancer of any type except minor skin lesions. B. Yes No Organic brain syndrome such as Alzheimer's disease. C. Yes No Chronic kidney disease. D. Yes No Are you currently disabled, hospitalized or confined to a facility such as a skilled nursing facility? E. Yes No Do you have any conditions for which treatment will include hospitalization or confinement to a facility in the next 12 months? F. Yes No Have you been hospitalized or confined to any facility more than once in the past 12 months?

If you answered yes to questions D, E, or F, please explain below.

Consumer Protection Information

- You do not need more than one Medicare supplement policy. If you purchase this policy, you may want to evaluate your existing coverage and decide if you need multiple coverages. 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 policy (or, if that policy is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If your 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).

To the Best of Your Knowledge

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 have 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 ANSWER ALL QUESTIONS.

- Do you have another Medicare supplement policy in force? Yes No (a) If so, with which company? (b) If so, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- Have you had any other health insurance coverage, other than Medicare Advantage, within the past 63 days? (For example, an employer, union, or individual plan) Yes No (a) If so, with which company? (b) What kind of policy? (c) What is the end date of coverage under the policy? / / (If you are still covered under the other policy, leave blank.) (d) Is this replacing group coverage? Yes No

Continued on back

3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? Yes No
- (a) If you had coverage from any Medicare plan other than original Medicare, fill in your end date below. If you are still covered by this plan, leave blank.
- (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this policy? Yes No
- (c) Was this your first time in this type of Medicare plan? Yes No
- (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

IMPORTANT NOTE: If you are replacing Medicare Advantage coverage, you must disenroll from your Medicare Advantage coverage and reestablish Medicare coverage before this policy takes effect. You can do this by calling 1-800-MEDICARE. If you are replacing your current Medicare supplement coverage, group coverage, Medicare HMO or PPO coverage or Medicare Advantage coverage with our Medicare supplement plan, the pre-existing conditions exclusions below will not apply to you.

4. Are you covered for medical assistance through the 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. Yes No 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

Agent Use Only

List health insurance policies you, the agent, have sold to this applicant which are still in force.

List health insurance policies you, the agent, have sold to this applicant in the past five years that are no longer in force.

Please Read and Sign this Portion of the Enrollment Form

READ CAREFULLY BEFORE SIGNING: To determine my insurability or for claims purposes, I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, institution or person, that has any past and future medical records or knowledge of my health, to give to Blue Cross and Blue Shield of South Carolina, or any of its reinsurers, any such information. I understand and agree that this authorization will remain valid: (a) for the purpose of collecting information to determine my insurability for 24 months from the date I sign this application; and (b) for the purpose of collecting information in connection with a claim for benefits for the period of time I am covered under the policy. I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of an Outline of Coverage and the Medicare Supplement Buyer's Guide from the agent whose signature is below.

I agree that the information given by me on this application is complete, true and correctly recorded and this application will become a part of my contract. My coverage will not become effective until this application is accepted by Blue Cross and Blue Shield of South Carolina and until the premium plus any policy fee is paid. Approval will be based on my insurability as stated in my application. Coverage will become effective on the first or the fifteenth of the month.

I understand that I must be a South Carolina resident, have both Medicare Parts A and B and be at least age 65.

I will have a six-month pre-existing limitation period from the effective date of the contract before I can receive benefits for any pre-existing conditions for which I have received medical advice or treatment during the six-month period immediately prior to my policy effective date.

Applicant's Signature: X Date _____

Agent's Signature: X Code _____ Date _____

Authorization Agreement for Bank Draft Payments

If you choose Monthly Bank Draft, complete the authorization agreement below and attach a voided check.

COMPANY NAME: Blue Cross and Blue Shield of South Carolina COMPANY ID NUMBER: 320396492

I authorize Blue Cross and Blue Shield of South Carolina to initiate debit entries to my checking account below and the Bank named to debit my account

BANK NAME _____ BANK ROUTING NUMBER _____

CITY _____ STATE _____ ZIP _____

MY ACCOUNT NO. _____ NAME ON ACCOUNT: _____

This authority is to remain in force until the Bank has received written notification from me of its termination in such time and such manner as to afford the Bank a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the Bank prior to charging the account. If Blue Cross and Blue Shield of South Carolina initiates an erroneous debit entry to a customer's account, the customer shall have the right to have the amount of the entry credited to his/her account by the Bank. If, within 15 calendar days following the date on which the Bank sent to the customer a statement of account or written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank a written notice identifying the entry, stating that the entry was in error and requesting the Bank to credit the amount to his/her account.

YOUR NAME _____

SIGNED X _____ DATE _____

For Use of Blue Cross and Blue Shield of South Carolina

Effective Date	End Date	Cancel	Process	I.D. Code	Accept	Reject	Underwriting