C Plus℠ with PMD

A Medicare Select Plan B

MEDICARE SUPPLEMENT CONTRACT APPLICATION

Be sure to read the important disclosures listed on the back before completing this application. Please use black ink and print clearly. Keep the white copy for your records. Mail the blue top copy in the return envelope which is included in your C Plus packet, or send to:

Blue Cross and Blue Shield of Alabama
Attention: C Plus Applications
PO Box 11551
Birmingham, Alabama 35282-9722

BlueCross BlueShield of Alabama

An Independent Licensee of the Blue Cross and Blue Shield Association.

ENR-246 (Rev. 10-2005)

PERSONAL INFORMATION

FOR OFFICE USE ONLY

APPLICANT'S NAME **(Last/First/Middle Initial)**

ADDRESS **(Number & Street)** CITY STATE ZIP

TELEPHONE # **(area code)**

( )

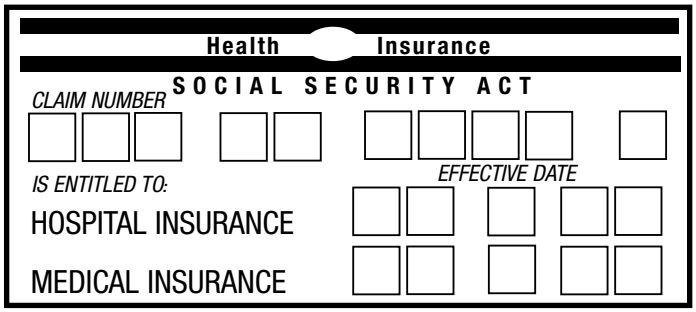
SOCIAL SECURITY NUMBER ☐☐☐-☐☐-☐☐☐☐

DATE OF BIRTH Month Day Year

SEX **(check one)** ☐ Male ☐ Female

MEDICARE INFORMATION

You must have Medicare hospital (Part A) and medical (Part B) coverage to enroll in C Plus. Please copy your information from your red, white and blue Medicare Card onto the card on the right.



1. Do you have the original Medicare Plan – the traditional Medicare plan offered by the federal government that lets you go to any health care provider who accepts Medicare? . . . . . ☐ YES ☐ NO

2. If 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), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START _____/_____/_____ **END** _____/_____/_____

   Please attach your disenrollment letter which shows the disenrollment date from that plan.

   a. 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

   b. Was this your first time in this type of Medicare plan? . . . . . ☐ YES ☐ NO

   c. Did you drop a Medicare supplement policy to enroll in the Medicare plan? . . . . . ☐ YES ☐ NO

ELIGIBILITY INFORMATION

TO THE BEST OF YOUR KNOWLEDGE:

1. a. Did you turn 65 in the last six months? . . . . . ☐ YES ☐ NO

   b. Did you enroll in Medicare Part B in the last six months? . . . . . ☐ YES ☐ NO

   c. If **yes**, what is the effective date? _____

2. Are you now entitled to Medicare as a result of disability? . . . . . ☐ YES ☐ NO

3. Do you have kidney failure, chronic renal disease or ESRD (End Stage Renal Disease)? . . . . . ☐ 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 (for example: an employer, union, or individual plan)? . . . . . ☐ YES ☐ NO

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

   Company _____ 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** _____/_____/_____

6. 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.) . . . . . ☐ 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

c. Are you presently living in a nursing home? . . . . . ☐ YES ☐ NO

d. Are you enrolled in the **Medicaid Nursing Home Program** which provides an increase in your maximum monthly income to pay premiums for supplemental coverage? . . . . . ☐ YES ☐ NO

CHOOSE YOUR TYPE PAYMENT

1. What is your requested effective date for C Plus Select Plan B?
This date may not be earlier than the date this application is received by us and must be effective on the first day of the month.

Month	Day	Year
	0 1	2 0 0

2. How do you want to pay for your new coverage? **(check one)**

☐ Automatic Premium Payment (Bank Draft)
(Complete the Authorization Agreement for Bank Draft in your C Plus packet)

☐ Coupon Book Monthly
☐ Coupon Book Bi-monthly
☐ Coupon Book Quarterly

☐ Annual Billing*
☐ Semi-Annual Billing*
*Begins with the contract effective date.

☐ Automatic Premium Payment (Credit Card)
(Complete the Authorization Agreement for Credit Card in your C Plus packet)

IMPORTANT: MEMBERSHIP AGREEMENT • PLEASE READ AND SIGN

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY:

I am applying for your C Plus Select Plan B Contract. If you accept this application, you will send me an Identification Card. I understand that acceptance of this application is subject to my answers to all questions, including the health information questions. I also understand that this application and the Contract, including all amendments, make up my entire contract with you.

If my fees are deducted from my pay I authorize my employer, if applicable, to deduct the amount of fees (or the part I pay) and send them to you.

If you do not accept my application, the only thing you have to do is to return any fees I paid. You may pay providers directly for services to me. I ask my doctor, hospital, Medicare or anyone else to give all medical records of me to you. You may release those records to anyone necessary in order to administer the contract. This begins now and continues as long as you need to decide about this application and process any of my claims.

I will cooperate with you if you need information about other health policies I have, including payments by them, I will give it to you. If you need information to help you subrogate (substitute for me or a family member) or be reimbursed, I will give it to you.

I understand that the C Plus Select Plan B Contract is a Medicare supplement and certify by my signature below that I am eligible for and enrolled in Parts A and B of Medicare. I understand and agree that Blue Cross and Blue Shield of Alabama engages in substantial interstate activity effecting interstate commerce, and that this agreement itself affects interstate commerce, and that, therefore any disagreement between us must be submitted to binding arbitration in accordance with the terms of the contract.

ACKNOWLEDGEMENT OF RECEIPT: OUTLINE OF COVERAGE

The undersigned hereby acknowledges that he/she has been given (i) the Outline of Coverage for C Plus Select Plan B, (ii) a description of the network providers and financial consequences of using non-network providers, (iii) a description of coverage for emergency and out of area services, and; (iv) a description of the quality assurance and grievance procedure under the policy.

ARBITRATION

THE CONTRACT YOU'RE APPLYING FOR INCLUDES BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT WILL BE SETTLED BY ARBITRATION — NOT A COURT. THE ARBITRATOR'S DECISION IS FINAL AND BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THIS DECISION CAN'T BE REVIEWED BY A COURT; THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE — AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE CONTRACT.

YOUR SIGNATURE _____ **DATE SIGNED** _____

This application is not complete unless it is signed and dated.
The application MUST be fully completed before we may determine your eligibility.

THE FOLLOWING INFORMATION IS REQUIRED BY FEDERAL REGULATIONS

Please be aware that:

(a) You do not need more than one Medicare supplement policy.

(b) If you purchase this policy, you should evaluate your existing health coverage and decide if you need multiple coverages.

(c) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(d) 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.

(e) 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.

(f) 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).