

# How to apply for a Blue Cross Blue Shield of Arizona Medicare Supplement Plan



An Independent Licensee of the Blue Cross and Blue Shield Association

Thank you for selecting Blue Cross Blue Shield of Arizona. If you have questions, need assistance completing the application or need additional application forms, please call your health insurance broker or Blue Cross Blue Shield of Arizona (BCBSAZ) at **(602) 864-4899 or (877) 864-4899**.

## You are eligible to apply if:

- In general, you are 65 years\* of age or older; and
- You are enrolled in Medicare Parts A and B; and
- You reside in Arizona if you are applying for Senior Security; or
- You reside in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal or Santa Cruz County if you are applying for Senior Preferred.

## You are not eligible to apply for a BCBSAZ Medicare supplement plan if:

- You are receiving or have been advised to receive kidney dialysis; you have end stage renal disease (ESRD), unless you are entitled to Guaranteed Issue rights, as described in Section 4. You may contact the State Health Insurance Assistance Program at (602) 542-6595, (800) 432-4040 Statewide, or TDD Line at (602) 542-6366 for information regarding plans that may be available to you if you have end stage renal disease.
- You are receiving disability benefits and are under age 65.
- You are not a resident of Arizona.
- You already have a Medicare supplement or Medicare Advantage policy and do not intend to replace it with this plan.

## Here's how to apply: *Please use dark ink. (Do not use red ink.)*

1. Complete, sign and date all sections as indicated by signature boxes.
2. If you are applying for Senior Preferred Medicare Select coverage, please read the Senior Preferred subsection in the Acknowledgements.
3. If you would like the convenience of automatic withdrawal for billing purposes, be sure to complete, sign, and date the Sure Pay Authorization form in Section 9.
4. If you would like Blue Cross Blue Shield of Arizona to share your personal information with another individual (such as a spouse, child or broker), please read the instructions and complete the Confidential Information Release Form included as part of this application. **This is an optional form.**
5. Mail the entire Application form to:  
**Attn: Cash Control**  
**P.O. Box 81049**  
**Phoenix, AZ 85069-1049**

We will return a copy to you. **Do not send any premium.** (If your application is approved, you will be billed if a contract is issued to you.)

\* Depending on your birthday, you may be eligible to apply during the time period when you are enrolled in Medicare Parts A and B and you are 64 if you are in your 65<sup>th</sup> birthday month or you turn 65 the first day of the month following your Medicare Part B coverage.

# Application for Medicare Supplement Coverage



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## 1 General Information

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Telephone Number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ E-mail address: \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender  M  F Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
(M M / D D / Y Y Y Y) (optional)

**Is your Billing address the same as above?**  Yes  No If no:

Billing Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

**Do you currently have Blue Cross Blue Shield of Arizona coverage?**  Yes  No If yes,

Contract Holder's Name \_\_\_\_\_

BCBSAZ Identification No. \_\_\_\_\_

**Medicare Number and Effective Dates.** Please copy this information exactly as it appears on your Medicare Card.

Medicare Card No. \_\_\_\_\_

Part A (Hospital): \_\_\_\_/\_\_\_\_/\_\_\_\_ Part B (Medical): \_\_\_\_/\_\_\_\_/\_\_\_\_  
(M M / D D / Y Y Y Y) (M M / D D / Y Y Y Y)

Part D (Prescription Drug Plan), if applicable: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(M M / D D / Y Y Y Y)

### SPACE BELOW FOR BROKER USE ONLY

BROKER NAME, MAILING ADDRESS AND PHONE	BROKER ID#	LID#

## 2 Your Billing Preferences

### How often do you prefer to be billed?

- Monthly
- Quarterly
- Semi-Annually
- Annually

### Please select a method of payment

- Sure Pay Electronic Bank Draft *Please complete the Sure Pay Authorization included with this application*
- Paper bill

## 3 Your Choice of Coverage

**You are eligible to apply if:** (1) You are, in general, 65 years of age or older; and (2) You are enrolled in Medicare Parts A and B; and (3) You reside in Arizona for Senior Security OR, you reside in a Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal or Santa Cruz County for Senior Preferred.

### Senior Security

Available throughout Arizona

- Plan A
- Plan C
- Plan F
- Plan N

### Senior Preferred (Medicare Select)

Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal and Santa Cruz counties

- Plan C
- Plan N

### Your Desired Effective Date

1st day of (month)

- |                                |                               |                               |
|--------------------------------|-------------------------------|-------------------------------|
| <input type="checkbox"/> Jan   | <input type="checkbox"/> May  | <input type="checkbox"/> Sept |
| <input type="checkbox"/> Feb   | <input type="checkbox"/> June | <input type="checkbox"/> Oct  |
| <input type="checkbox"/> Mar   | <input type="checkbox"/> July | <input type="checkbox"/> Nov  |
| <input type="checkbox"/> April | <input type="checkbox"/> Aug  | <input type="checkbox"/> Dec  |

## 4 Eligibility 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 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. Please mark Yes or No below.

I. (a) Do you have another Medicare supplement policy in force?  Yes  No

(b) If so, with what company and what plan do you have? \_\_\_\_\_

(c) If so, do you intend to replace your current Medicare supplement policy with this new Medicare supplement policy?  Yes  No

**If you answered "Yes" to questions I (a) and (c) above, and an agent is assisting you in purchasing this plan, be sure that your agent provides you with a completed "Notice to Applicant" form as part of this application. The Notice to Applicant form is located at the end of this application.**

II. (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

- III. (a)** Are you covered for medical assistance through a 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,**
- (b)** Will Medicaid pay your premiums for this Medicare supplement policy?  **Yes**  **No**
- (c)** Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?  **Yes**  **No**

- IV. (a)** Did you have 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**

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

START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ( M M / D D / Y Y Y Y ) ( M M / D D / Y Y Y Y )

- (b)** 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**
- (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**

- V. (a)** Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union or individual plan.)  **Yes**  **No**

**(b)** If so, with what company and what kind of policy? \_\_\_\_\_  
 \_\_\_\_\_

- (c)** What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START \_\_\_\_/\_\_\_\_/\_\_\_\_ END \_\_\_\_/\_\_\_\_/\_\_\_\_  
 ( M M / D D / Y Y Y Y ) ( M M / D D / Y Y Y Y )

- (d)** Did you receive a notice of termination from your current health insurer, employer, union or individual plan?  **Yes**  **No**

**IF YES, PLEASE INCLUDE A COPY OF THE NOTICE WITH YOUR APPLICATION.**

# 5 Health Status

If you answered "yes" to both questions (a) and (b) in Section 4 - Part II, skip this section and go to Section 6.

Your answers to the medical questions listed below will help determine if you are eligible to receive Senior Security or Senior Preferred coverage at the BlueValue rate. If you leave a question blank, your application will be considered incomplete and returned to you. BCBSAZ will advise you of the exact rate required for the coverage you selected once your enrollment application is processed.

- 1. Are you receiving or have you been advised to receive kidney dialysis?  Yes  No
- 2. Are you currently hospitalized or in a skilled nursing facility?  Yes  No
- 3. Have you been advised to have any type of surgery (excluding dental) that has not yet been performed?  Yes  No
- 4. Have you been advised that you need to have, or have you ever had, a transplant?  Yes  No
- 5. Within the last 5 years, have you been treated or diagnosed with any type of cancer (other than skin cancer)?  Yes  No
- 6. Within the last 5 years, have you been treated for or advised by a physician to have treatment for alcoholism or drug addiction requiring inpatient or outpatient treatment?  Yes  No
- 7. In the last 5 years, have you been hospitalized for any psychological or mental disorder(s)?  Yes  No
- 8. Are you currently using or have you used tobacco products in the last year?  Yes  No
- 9. Have you ever been diagnosed or treated for AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)?  Yes  No
- 10. Have you ever been diagnosed or treated by a licensed health care provider for any of the following:
  - a. Alzheimer's disease, senile dementia  Yes  No
  - b. Rheumatoid arthritis, myasthenia gravis, lupus, multiple sclerosis, amyotrophic lateral sclerosis (ALS)  Yes  No
  - c. Diabetes (Type I or Type II)  Yes  No
  - d. Emphysema, chronic obstructive pulmonary disease (COPD), tuberculosis, (not including asthma)  Yes  No
  - e. Heart attack or stroke (including TIA), cardiac surgery (including coronary bypass surgery or angioplasty), rhythm disorders requiring a pacemaker?  Yes  No
  - f. Cirrhosis, hepatitis B or hepatitis C  Yes  No
  - g. Parkinson's disease  Yes  No

Please list the name and phone number of your physician(s). If needed, continue your list on a separate sheet of paper.

\_\_\_\_\_  
Treating Physician's name (\_\_\_\_\_) Phone number

\_\_\_\_\_  
Treating Physician's name (\_\_\_\_\_) Phone number

## 6 For Your Protection

- I. You do not need more than one Medicare supplement policy.
- II. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- III. You may be eligible for benefits under Medicaid\* and may not need a Medicare supplement policy.
- IV. If, after purchasing this policy, you become eligible for Medicaid\*, the benefits and premiums under your BCBSAZ 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 reinstated 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.
- V. Counseling services may be available in Arizona to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid\* program, including benefits such as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

\*Arizona Health Care Cost Containment System (AHCCCS) is Arizona's Medicaid program.

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## 7 Acknowledgments – read this section and sign at the end

- I. I have carefully read all of this application form and the information I provided. I understand and agree that it will be part of my contract with Blue Cross Blue Shield of Arizona (BCBSAZ).
- II. I understand and agree that:
  - the information I've provided is material to BCBSAZ's decision to offer health care coverage;
  - BCBSAZ will rely on the accuracy of the information to determine my eligibility for coverage;
  - BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage, if BCBSAZ discovers a material misrepresentation or omission after issuing coverage.
  - coverage will be effective only after BCBSAZ has accepted and reviewed this application and assigned an effective date.
  - coverage will be subject to the benefits, limitations and provisions, of the BCBSAZ benefit plan, regardless of other coverage I may have had in the past;
  - if I have misstated or omitted any information that resulted in my appearing eligible for the BlueValue premium rate, BCBSAZ may change my premium rate to the higher standard rate as of the effective date of my coverage.
- III. I acknowledge that I have received an Outline of Coverage for BCBSAZ's Senior Security and Senior Preferred plans.
- IV. I acknowledge that I have received a copy of the "Guide to Health Insurance for People with Medicare."

V. I understand that:

- BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance brokers.
- Commission payments to brokers are one of the costs factored into premiums, but BCBSAZ’s premium calculation is not based on whether a product is sold directly or by a broker.
- BCBSAZ generally pays a commission to the broker of record or permitted assignee until this contract is terminated or the contract holder terminates his/her relationship with the broker or the broker becomes ineligible.
- BCBSAZ broker contracts require the broker to give me information on the broker’s commission rate with BCBSAZ. I can also get more detailed information about broker commission and compensation paid to BCBSAZ licensed inside sales representatives for sales of BCBSAZ individual products at azblue.com or by calling BCBSAZ at (602) 864-4021.

**VI. For Senior Preferred Applicants Only – Medicare Select Acknowledgment**

If you are applying for Senior Preferred Medicare Select Plan C or Plan N (available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal and Santa Cruz counties only), please read this section. I acknowledge that I have received the following information and understand the restrictions of the Senior Preferred benefit plan:

- An Outline of Coverage comparing the Senior Preferred Medicare Select benefit plan and premium with the Senior Security benefit plans and premiums, which includes the following:
  - A description of benefits available when Senior Preferred or non-Senior Preferred providers are used
  - A description of coverage for emergency and out-of-service-area care
  - A description of limitations on referrals to non-Senior Preferred providers
  - A description of my right to purchase a Senior Security plan
  - A description of BCBSAZ’s quality assurance program and complaint and grievance procedure
- A Senior Preferred provider directory

<b>Applicant’s Signature</b> _____	Date _____ / _____ / _____ ( M M / D D / Y Y Y Y )
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**8 TO BE COMPLETED BY THE AGENT:** Agents shall list any other health insurance policies sold to the applicant.

I. Have you sold any other health insurance policies to the applicant, either in force or within the last five (5) years?  **Yes**  **No**

II. List all health insurance policies sold to the applicant that are still in force.

\_\_\_\_\_

\_\_\_\_\_

III. List all health insurance policies sold to this applicant in the past five years that are no longer in force.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

<b>Agent’s Signature</b> _____	Date _____ / _____ / _____ ( M M / D D / Y Y Y Y )
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# 9 Sure Pay Authorization

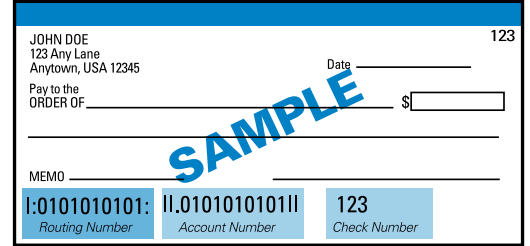
**Save the trouble of writing us a check.** With Sure Pay, there's no bill to keep track of, no check to write, and nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account.

**If the first deduction is delayed, the initial amount may be more than one monthly premium.**

## Electronic Billing Information

### Pay your premiums the convenient way with Sure Pay

Please debit my:  Checking  Savings



**ROUTING TRANSIT NUMBER** \_\_\_\_\_

**ACCOUNT NUMBER** \_\_\_\_\_

## To the Financial Institution

- I authorize BCBSAZ to start an automatic periodic charge to my checking or savings account as noted above. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.
- I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Sure Pay service. I agree to allow a reasonable time for discontinuation of Sure Pay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Sure Pay withdrawals.
- I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.
- I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month or twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.
- I have read and agree to abide by the Sure Pay conditions as outlined on this authorization form. I understand any applicable refund of monies due will be released 30 days after the last draft date.

**Authorized signature on account** \_\_\_\_\_ Date \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ ( M M / D D / Y Y Y Y )

# Confidential Information Release Form



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Please complete the Confidential Information Release Form if you would like Blue Cross Blue Shield of Arizona (BCBSAZ) to share your personal information with the individual or organization you specify on the form. Each individual 18 and over should complete a separate form.

**This authorization is voluntary. We will not condition our claim payment activities, your enrollment in our health plan or your eligibility for benefits on you giving us this authorization.**

## Examples of Use

Here are a few examples for which the form may be used. Complete the form if you would like BCBSAZ to share certain or all of your personal information with:

- Another adult such as a spouse, parent, child or personal representative so they can discuss your claims or billing questions with BCBSAZ.
- Your broker during or after the enrollment process for the level of service he or she is to provide (enrollment, claims and/or billing questions, etc.)
- Your attorney for a specific legal issue that arises, such as a personal injury case.

## Specific Instructions

**Information to be Disclosed:** Indicate the specific information you want to share (application, enrollment, eligibility, EOBs, claims, medical records, etc.)

**Person Whose Information May Be Released:** Enter the name of the person whose information should be disclosed. This will normally be your name.

**Who May Receive the Indicated Information:** Tell us who you are authorizing to receive your information.

**Purpose of Use/Disclosure:** Tell us why you want us to share your information.

**Authority to Update My Records:** Tell us if the person you indicate is authorized by you to update our records if you move to a different address, change banks or change bank accounts.

**Expiration Date:** This authorization will automatically expire 90 days after your last coverage date. You have the right to revoke this authorization earlier by contacting the Privacy Office.

**Identification Number and Group Number:** Enter your BCBSAZ ID number if you've received one; otherwise enter your social security number.

**Signature:** Print and sign your name and date the form.

**Group Name and Number:** If applicable, enter the name and number of the employer or other insured group under which you are covered.

**Personal Representative:** A personal representative is a legal designation and generally refers to parent of an unemancipated minor, Legal Guardian, or Holder of Power of Attorney. If you are the Personal Representative and are completing this form for someone else, please complete the last two rows and attach copies of relevant legal documents.

# Confidential Information Release Form

(To authorize BCBSAZ to disclose and/or update your information)



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You must use a separate form for the release of HIV-related information. Return this completed form with your application. Current BCBSAZ customers should mail this completed form to Blue Cross Blue Shield of Arizona, Attention: Enrollment Services, P.O. Box 13466, Phoenix, AZ 85002. Blue Cross Blue Shield of Arizona (BCBSAZ) will not condition its payment activities in connection with your claims, your enrollment in our health plan or your eligibility for benefits in our health plan on you giving this authorization.

**Information to be Disclosed:** I authorize BCBSAZ to disclose the following information, including information about communicable diseases, alcohol and drug abuse treatment and genetic testing: (Please check all that apply.)

- |   |  |
|---|--|
| <input type="checkbox"/> Application, Enrollment, Eligibility Information | <input type="checkbox"/> Billing/Payment Information |
| <input type="checkbox"/> Claims/EOB Information                           | <input type="checkbox"/> Medical Records             |
| <input type="checkbox"/> Precertification Information                     | <input type="checkbox"/> Account Information         |
| <input type="checkbox"/> Other (please describe): _____                   |  |

**Person Whose Information May Be Released:** \_\_\_\_\_

**Who May Receive the Indicated Information:**

Name: \_\_\_\_\_  
Company Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City, State, Zip Code: \_\_\_\_\_

**Purpose of Use/Disclosure:**

- |  |   |
|--|---|
| <input type="checkbox"/> To assist with obtaining a health care policy | <input type="checkbox"/> To assist with claims processing and/or payments |
| <input type="checkbox"/> Other Purpose of Use/Disclosure: _____        |   |

**Authority to Update My Records:** I also authorize \_\_\_\_\_ to be able to:

- |  |  |
|--|--|
| <input type="checkbox"/> Change My Mailing Address | <input type="checkbox"/> Update My SurePay/Banking Information |
|--|--|

Unless you revoke this authorization earlier, it will expire 90 days after the expiration or termination of your coverage with BCBSAZ. It is possible for the protected health information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and no longer protected by federal health information privacy laws. **You may revoke this authorization by giving written notice to the BCBSAZ Privacy Office, Mail Stop C302, P.O. Box 13466, Phoenix AZ 85002-3466. Revocation of this authorization will not affect any action BCBSAZ took in reliance on this authorization before it received your written notice of revocation.**

Printed Name _____	Identification Number _____
Signature _____	Date (mm/dd/yyyy) _____
Group Name (if applicable) _____	Group Number (if applicable) _____
Personal Representative's Name* _____	Relationship to Individual _____
Personal Representative's Signature _____	Date (mm/dd/yyyy) _____

\* Please attach a copy of the relevant legal document(s)

**You are entitled to a copy of this authorization after you sign it. You may refuse to sign this authorization.**

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE COVERAGE

Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

### SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing Medicare supplement contract or Medicare Advantage insurance and replace it with a contract to be issued by Blue Cross Blue Shield of Arizona. Your new contract to be issued by Blue Cross Blue Shield of Arizona will provide thirty (30) days within which you may decide without cost whether you desire to keep the contract. 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 contract.

#### 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 contract 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 contract 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 Part D.
- Disenrollment from a Medicare Advantage plan. Explain reasons for disenrollment. \_\_\_\_\_
- Other. (Please specify) \_\_\_\_\_

If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application which requests that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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 contract and are sure you want to keep it.**

\_\_\_\_\_  
(Signature of Agent, Broker, or Other Representative)

Applicant's Signature _____	Date _____ / _____ / _____ ( M M / D D / Y Y Y Y )
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\_\_\_\_\_  
(Signature of Agent, Broker, or Other Representative)

Applicant's Signature _____	Date _____ / _____ / _____ ( M M / D D / Y Y Y Y )
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