How to apply for a Blue Cross Blue Shield of Arizona
MEDICARE SUPPLEMENT PLAN

BlueCross BlueShield of Arizona

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 **888-264-1733**.

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 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.
- You meet any of the conditions below, unless you are entitled to Guaranteed Issue rights, as described in the CMS brochure, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," which BCBSAZ makes available with this application. 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 or have been advised to receive kidney dialysis
  - **You have end stage renal disease (ESRD)**
  - You have been diagnosed with a kidney disease that may require kidney dialysis.
  - You have had an inpatient admission into a hospital within the last 90 days.
  - You are currently in the process of a medical work-up or treatment for an unresolved condition related to any of the following:

    Organ transplant, back or spine surgery, joint replacement, surgery for cancer, heart surgery, vascular surgery

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.
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: Blue Cross Blue Shield of Arizona**
   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 when a contract is issued to you.)

* You may apply during the time period when you are enrolled in Medicare Parts A and B and you are 64, if there is no more than 90 days until the 1st day of the month you turn 65.

OFFICE COPY

Please return this copy with your application

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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 have now. 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)

CUSTOMER COPY

Please keep this copy for your records.

BlueCross BlueShield of Arizona

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(**Signature of Agent, Broker, or Other Representative**)

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

Blue Cross Blue Shield of Arizona (BCBSAZ) does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print and accessible electronic formats. We also provide free language services to people whose primary language is not English, such as qualified interpreters and written information in other languages. If you need these services call 602-864-4888 (TTY/TDD: 602-864-4823). If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the BCBSAZ Civil Rights Coordinator at Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, 602-864-2288, TTY/TDD: 602-864-4823, crc@azblue.com. You can file a grievance by phone or by mail, fax, or e-mail. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

BlueCross BlueShield of Arizona

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