



## Instructions

- For guaranteed issue coverage, you must be age 65 or over, reside in Texas, have Medicare Part A and be within 6 months of eligibility for Medicare Part B.
- If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s). Send no money now! No payment is due until you have a chance to review your policy and make sure the coverage is right for you.

## A. Plan Selection

I would like to apply for Medicare Supplement: **(check only one box)**

<input type="checkbox"/> <b>Plan A</b>	<input type="checkbox"/> <b>Plan F</b> Standard Medicare Select	<input type="checkbox"/> <b>Plan F</b> High Deductible	<input type="checkbox"/> <b>Plan G</b> Standard Medicare Select
<input type="checkbox"/> <b>Plan K</b> Standard Medicare Select	<input type="checkbox"/> <b>Plan L</b> Standard Medicare Select	<input type="checkbox"/> <b>Plan N</b> Standard Medicare Select	

Make policy effective:            
MONTH DAY YEAR

*See the enclosed Outline of Coverage for rate information*

## B. Personal Information

Name (First, Middle, Last)				
Home Address		City	State <b>TEXAS</b>	Zip
Correspondence/Billing Address		City	State	Zip
Primary Phone ( ) ( )	Secondary Phone ( ) ( )	Age	Birthdate ____/____/____ Mo. Day Year	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security Number ____-____-____	E-mail address		

## C. Payment Option (Select One)

- Premium **deducted from my bank account:** (Financial Institution Debit Authorization)  
 Electronic Fund Transfer Account Type:  Checking  Savings  
 Account holder name: \_\_\_\_\_  
 Bank account number: \_\_\_\_\_ Bank routing number: \_\_\_\_\_  
 Account Owner Signature (if different than applicant) **X** \_\_\_\_\_
- Premium **to be billed by mail**
- I will pay my premium:  Monthly  Bi-Monthly  Quarterly  Semi-Annually  Annually

Applicant Name \_\_\_\_\_

## D: Medicare Claim Number

Please copy the Medicare Claim Number from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Your Medicare Claim No. - Part A Effective Date: \_\_\_\_ / **01** / \_\_\_\_

## E: Consumer Protection Information

Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.

1. Did you turn age 65 in the last 6 months? Yes  No
2. Did you enroll in Medicare Part B in the last 6 months? Yes  No   
**If yes**, what is the effective date? \_\_\_\_ / \_\_\_\_ / \_\_\_\_
3. 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.*
  - a. **If yes**, will Medicaid pay your premiums for this Medicare Supplement policy? Yes  No
  - b. **If yes**, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes  No
4. 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. *(If you are still covered under this plan, leave "END" blank.)*  
**Start:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**End:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_
  - 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
5. Do you have another Medicare Supplement or Medicare Advantage policy in force? Yes  No 
  - a. **If yes**, with what company, and what plan do you have? \_\_\_\_\_
  - b. **If yes**, do you intend to replace your current Medicare Supplement or Medicare Advantage policy? Yes  No
6. Have you had coverage under any other health insurance within the past 63 days? Yes  No 
  - a. If so, with what company, and what kind of policy?  
*(For example, an employer, union, or individual plan)* \_\_\_\_\_
  - 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:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Applicant Name \_\_\_\_\_

## Important Information Regarding Medicare Supplement Coverage:

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 more than one type of coverage in addition to your Medicare benefits. 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 reinstated if requested within 90 days of losing Medicaid eligibility.\* 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 reinstated 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.

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). For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

I hereby apply for coverage and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.

I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.

**Please sign the signature line below.**

**SIGNATURE** *Must be signed in ink and dated to avoid delays in processing.*

I have read and understand the statements on the reverse side regarding Medicare Supplement coverage. If choosing Medicare Select, I have also read and understand the statements regarding Medicare Select as described in the Outline of Coverage. I have received the appropriate Outline of Coverage.

Please sign here in ink: **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## Questions?

Call us at our Customer Service toll-free number 1-888-731-0415,  
call your insurance agent at the number listed below, or visit [www.bcbstx.com](http://www.bcbstx.com).

**Applicant Name** \_\_\_\_\_

**Proxy Statement:** The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof (“HCSC”), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned’s proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

**Primary Applicant’s Signature** (optional): **X** \_\_\_\_\_

Print Your Name as You Signed It: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

**Agent Information** (If Applicable)

*The following statements apply if you are purchasing coverage through an agent:*

- The undersigned acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
- The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, he/she should contact the agent.
- The applicant(s) have received a copy(s) of the Medicare Supplement Buyers Guide.

Any other health insurance policies or coverages sold to the applicant which are still in force:

\_\_\_\_\_

Any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

\_\_\_\_\_

I have reaffirmed that the information supplied on this application is accurate and complete.

**Signature:** **X** \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Print name: \_\_\_\_\_ Texas Broker Code: \_\_\_\_\_

Agency name (If Applicable): \_\_\_\_\_ Phone: ( ) \_\_\_\_\_