

How to Apply for the Senior Blue Medicare Supplement Policy

You can apply in just a few simple steps, and it won't take a lot of your time. If you have questions regarding the enrollment process, call Dick Applequist or Kristi Nordquist at 332-5300, and we will answer any of your questions.

Eligibility Requirements

To enroll in Senior Blue you must

- Be a resident of South Dakota
- Be enrolled in Medicare Part A and Part B
- And not be covered by another Medicare supplement policy unless you intend to replace your other policy

Choose Your Senior Blue Plan

- Read our explanations and outlines of coverage carefully
- Determine which of the six plans are best for you
- Your premium is shown for your age

Complete and mail items to us

- Complete the application form. Please use an ink pen to complete the application. We will send a copy of your original application back to you for your records.
- Complete the "Authorization for Automatic Account Withdrawal" form along with a voided check if you want your premiums automatically withdrawn from your account monthly, quarterly or semi-annually. (if you choose to pay your premiums monthly, you must have them automatically withdrawn from your account.)
- If you have a present Medicare supplement policy that you are replacing fill out and sign the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance".
- Enclose a check for your first month, quarter, or 6 month premium. Multiply the monthly premium by 3 for the quarter or 6 for the six month premium.

APPLICATION FOR

SeniorBlue[®]

Medicare Supplement



An Independent Licensee of the Blue Cross and Blue Shield Association

Instructions for completing this application

To ensure complete and accurate processing of your application, **PLEASE:**

- Complete all applicable sections
- Use **BLACK PEN**

checklist:

- Did you indicate the benefit plan for which you are applying?
- If you want your premium automatically deducted from your checking account, have you included a voided check?
- Have you marked “YES” or “NO” to each health question (if applicable)?
- If you made any changes to this application, did you initial that change?
- Have you signed and dated the application?

FB Member #	FB County #	Group Billing Unit	Monthly Premium	Policy Effective Date
Name (First, Middle, Last)			My Social Security No.	
Address				Apt. #
City		State	Zip Code	County #
Home Phone No. ()		Date of Birth		Sex <input type="checkbox"/> M <input type="checkbox"/> F
Are you a resident of South Dakota? <input type="checkbox"/> NO <input type="checkbox"/> YES	Is this application for reinstatement of a policy which lapsed due to nonpayment of premium? <input type="checkbox"/> NO <input type="checkbox"/> YES	Is this application for reinstatement of a policy which was suspended? <input type="checkbox"/> NO <input type="checkbox"/> YES		

MEDICARE INFORMATION (As shown on your Medicare ID Card)

1. Health Insurance Claim No. (Medicare ID No.): Alpha Letter
2. Hospital Insurance (Part A) Effective Date: (month/day/year) _____
3. Medical Insurance (Part B) Effective Date: (month/day/year) _____

HEALTH QUESTIONS

You do not need to complete these health questions if you are applying for Plan A or for guaranteed-issue Plan C or if you are applying during the six-month open enrollment period which begins the month you were enrolled in Medicare Part B.

1. Within the last two years, have you received medical advice or prescription drugs for liver problems, internal cancer, stroke, Amyotrophic Lateral Sclerosis (ALA), Multiple Sclerosis (MS); or within the last two years have you had heart or bypass surgery or angioplasty? YES NO
2. Have you received medical treatment or prescription drugs for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC) and/or tested HIV positive? YES NO
3. Do you currently use an oxygen device or require dialysis for kidney disease? YES NO

NOTE: The following statements are true if you are not applying during the six-month open enrollment period:

- If you answer "YES" to questions 1, 2, or 3, you are only eligible to apply for Plan A or guaranteed-issue Plan C.

CONTRACT INFORMATION

- Check the Senior Blue Plan for which you are applying:
- | | | |
|---------------------------------|---------------------------------|---|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan E |
| <input type="checkbox"/> Plan F | <input type="checkbox"/> Plan L | <input type="checkbox"/> Guaranteed-Issue C |

How do you want to pay your premiums?

- Direct bill, if so on what basis: Quarterly Semi-Annually Annually
- Automatic Account Withdrawal, if so on what basis: Monthly Quarterly Semi-Annually Annually

NOTE: All billing periods are based on a calendar year.

On what date: 1st of the Month 5th of the Month

- Do you want it deducted from:
- Checking-attach a voided check (If applicant is not the payor, pre-authorization form (M-3506) is needed.)
 - Savings-attach a voided check (If applicant is not the payor, pre-authorization form (M-3506) is needed.)

OTHER INSURANCE INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your previous insurer stating that 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 previous insurer with your application. PLEASE ANSWER ALL QUESTIONS.

[Please mark YES or NO below with an "X"]
To the best of your knowledge,

(1)(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

(c) If yes, what is the effective date? _____

(2) 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,

(c) Will Medicaid pay your premiums for this Medicare supplement policy? YES NO

(d) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare part B premium? YES NO

(3)(a) 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 ___/___/___

(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

(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?

(c) If so, do you intend to replace your current Medicare supplement policy with this policy? YES NO

(d) If so, what is the paid-to or expiration date of your policy: ___/___/___

(5) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan?)

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

(b) What are your dates of coverage under the other policy? START ___/___/___ END ___/___/___
(If you are still covered under the other policy, leave "END" blank.)

APPLICANT SIGNATURE

I have read the statements and the agreement and certification on the back of this application.

Applicant's Signature **X** _____ Date: _____
(If POA, submit copy of legal authorization)

Agent Name _____ Signature _____
(Please Print)

Agent No. _____

STATEMENTS

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 your 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.
5. 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.
6. 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).
7. Premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium would be for the first day of a month through the last day of such month. A quarterly payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium would be for January 1 through December 31 of the applicable year.

AGREEMENT AND CERTIFICATION

Your signature on the front of this application verifies that you have received a “Senior Blue Medicare Supplement Outline of Coverage,” a “Guide to Health Insurance for People with Medicare,” and a completed copy of this application.

Your signature also verifies that, to the best of your knowledge and belief, you have answered the questions on this application truthfully and completely and you understand that your coverage will not begin until this application and payment submitted are received and accepted by us and an effective date is assigned by us.

Your signature also verifies that you authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of South Dakota when reasonably related to the health care coverage you have applied for. If any law or regulation requires additional authorization for release of medical records, you will give this authorization.

Authorization for Automatic Account Withdrawal

(Please return this authorization form with your payment)



YES, I authorize Wellmark Blue Cross and Blue Shield of South Dakota/USable Life to make automatic withdrawals for the amount of my premiums from the account shown on the enclosed voided check or deposit slip.

Insured's Name _____

Insured's Identification Number _____

Payment Frequency (check one) Monthly Quarterly Semi-Annually Annually

When do you want withdrawals taken from your account? (check one)
 1st of the month 5th of the month (USable Life withdraws on the 4th of the month)

What type of account is this? Checking Savings

1. Will premiums be paid through a business account? Yes No
2. If submitting a business check, are there any other employees besides you? Yes No
If yes, premiums cannot be withdrawn from this business account. You must submit personal account information.
3. Will your premium payment for this coverage be deducted on your federal income tax return other than the special health insurance deduction available to self-employed persons? Yes No
If yes, premiums cannot be withdrawn from this business account. You must submit personal account information.

Account Signature(s)*

Date _____

*If Power of Attorney or Legal Guardian, please include a copy of those documents.

Wellmark Blue Cross and Blue Shield of South Dakota must receive your signed authorization at least 20 days before your next payment is due in order to start the first automatic withdrawal. If your account balance is not sufficient to pay your premium, we will notify you of the amount due to continue your coverage.

Wellmark Blue Cross and Blue Shield of South Dakota reserves the right to implement premium rate increases regardless of your Payment Frequency choice. Whether you choose to pay monthly, quarterly, semi-annually, or annually, premium rate increases will be applied as determined by Wellmark.

For example, if you pay semi-monthly, you may have to make an additional premium payment to Wellmark for any increase in premium rate applicable for the semi-monthly period for which you previously made a premium payment.

Why Consider Automatic Account Withdrawal?

No checks to write. No stamps to buy. No trips to the mailbox. Just tell us the checking or savings account from which you want your premium payment withdrawn, and your payments are made to us automatically—just as though you had written us a check, minus the time and bother.

It's Convenient

You choose when you want to pay—monthly, quarterly, semi-annually or annually. Your premium will be paid on the first of the month when a payment is due.

It's Dependable

Your payment always arrives on time—even when you're away on business or pleasure, or just too busy to write and mail checks. The statement from your financial institution shows the withdrawal and serves as proof of payment.

It's Easy

Just fill out and sign the attached authorization form, attach a **voided check** or pre-printed **deposit slip** for the account, and return them to us with your next payment.

It's Free

In fact, you save the cost of postage, and so do we.

If you are not interested in automatic account withdrawal, but are interested in changing your current billing option, please call our Customer Service Department at

1-800-831-4818



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NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

Wellmark Blue Cross and Blue Shield of South Dakota
P.O. Box 5023
Sioux Falls, SD 57117-5023

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

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

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER OR ISSUER'S AGENT:

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage to the best of my knowledge. The replacement policy is being purchased for the following reason (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other. (please specify) _____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for Wellmark Blue Cross and Blue Shield of South Dakota to deny any future claims and to refund your premium as though your policy 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 present policy until you have received your new policy and are sure that you want to keep it.

(Signature of Agent, Broker, or Other Representative)

(Applicant's Signature)

(Date)

White – Wellmark

Canary – Agent

Pink – Applicant