



NOTICE TO APPLICANT

Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

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

According to information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by Highmark Blue Cross Blue Shield. 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 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 policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy 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 policy is being purchased for the following reason - *check one*:

- Additional benefits. No change in benefits, but lower premium. Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____
- Other (*please specify*): _____

Signature of Producer or other Representative, if applicable	Date
Name and Address of Producer or other Representative	

1. Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. 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 the company 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.
4. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Applicant's Signature _____ Date _____

Please sign this form and mail in a copy with your application.

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FOR HIGHMARK BLUE CROSS BLUE SHIELD USE ONLY	
Applicant's Name	
Medicare Number	Date Mailed