APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

Highmark Blue Cross Blue Shield
PO Box 4208 • Buffalo, NY 14240-9800
1-866-456-8140 (TTY 711)

The sale of a Medicare Supplement policy is prohibited where an individual has a Medicare Supplement policy in force and does not desire to replace the existing policy or where the Medicare Supplement policy would duplicate benefits to which the individual is entitled under a Medicare Advantage Plan.

PART 1 **PLEASE CHECK WHICH PLAN YOU WANT TO ENROLL IN**

- ☐ Plan A
- ☐ Plan B
- ☐ Plan C*
- ☐ Plan F*
- ☐ Plan F High Deductible*
- ☐ Plan G
- ☐ Plan N

*Plans C, F, and High Deductible F are only available to beneficiaries who were first eligible for Medicare prior to January 1, 2020.

Effective Date _____

PART 2 **PLEASE TELL US ABOUT YOURSELF**

Last Name _____ First Name _____ Middle Initial __

Date of Birth (MM/DD/YYYY) _____ Gender ☐ M ☐ F ☐ Mr. ☐ Mrs. ☐ Ms.

Email Address _____

PERMANENT RESIDENCE ADDRESS (P.O. BOX IS NOT ALLOWED):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

Home Phone Number ( ) _____ Alternative Phone Number ( ) _____
area code area code

MAILING ADDRESS (ONLY IF DIFFERENT FROM PERMANENT ADDRESS):

Street/Apartment # _____

City _____ State _____ County _____ Zip Code _____

PART 3 **MEDICAL ELIGIBILITY INFORMATION**

Provide Medicare information as it appears on Medicare identification card.

Name (as it appears on your Medicare card):

_____

Medicare Number

_____

Entitled to:

Hospital (Part A) Effective Date _____/ _____/ _____

Medical (Part B) Effective Date _____/ _____/ _____

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ENR-397 (R2-24)

PART 4 **MISCELLANEOUS ENROLLMENT INFORMATION**

If you need help completing this application, please call our Sales department at 1-877-258-7453 (TTY 711). We're available 8 a.m. to 8 p.m., 7 days a week from October 1 to March 31, and 8 a.m. to 8 p.m., Monday - Friday from April 1 to September 30.

Please answer completely and to the best of your knowledge and belief.
Please mark *Yes* or *No* with an *X*.

1. **a.** Did you turn age 65 in the last six months? ☐ Yes ☐ No

b. Did you enroll in Medicare Part B in the last six months? ☐ Yes ☐ No

If yes, what is the effective date? (MM/DD/YYYY) _____

2. 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.

If yes,

a. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No

b. Did you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Yes ☐ No

3. If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO, or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave **end date** blank.

Start date (MM/DD/YYYY) _____ End date (MM/DD/YYYY) _____

a. If you are still covered under the Medicare Advantage 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 Advantage plan? ☐ Yes ☐ No

c. Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ☐ Yes ☐ No

4. Do you have another Medicare Supplement or Medicare Select policy or certificate in force? ☐ Yes ☐ No

a. If so, with what company, and what plan do you have?

Company _____ Plan _____

b. Identification number _____

c. If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy or certificate? ☐ Yes ☐ No

5. Have you had coverage under any other health insurance policy or certificate within the past 63 days (for example, an employer, union, or individual plan)? ☐ Yes ☐ No

a. If so, with which company? _____

b. What type of policy? _____

c. Identification number _____

d. What are your dates of coverage under the other policy?

Start date (MM/DD/YYYY) _____ End date (MM/DD/YYYY) _____

If you are still covered under the other policy, leave **end date** blank.

PART 5 **PLEASE READ AND SIGN BELOW**

1. You do not need more than one Medicare Supplement policy or certificate.
2. If you purchase this policy (certificate), you may want to evaluate your existing health care 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 (certificate).
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy (certificate) may 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 (certificate) (or, if that is no longer available, a substantially equivalent policy) will be reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of 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. If you still wish to terminate your present policy or certificate and replace it with new coverage, review the application carefully before you sign it to be certain all information has been properly recorded.
   Do not cancel your present coverage until you have received your new policy (certificate) and are sure you want to keep it.
8. By my signature below, I acknowledge that I have received the currently available Medicare Supplement Outline of Coverage document.

PART 6 **ENROLLEE AUTHORIZATION — SIGNATURE**

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

_____ _____

Signature **Today's Date**

If you are an authorized representative, you must sign above and provide the following information:

Last Name _____ First Name _____ Middle Initial ___

Street/Apartment#_____

City _____ State _____ County _____ Zip Code_____

Home Phone Number ( ) _____ Relationship to Enrollee _____
area code

Answering these questions is your choice. You can't be denied coverage because you don't fill them out.

Are you Hispanic, Latino/a, or Spanish origin? Select all that apply.

- ❑ No, not of Hispanic, Latino/a, or Spanish origin
- ❑ Yes, Puerto Rican
- ❑ Yes, another Hispanic, Latino/a or Spanish origin
- ❑ **I choose not to answer.**
- ❑ Yes, Mexican, Mexican American, Chicano/a
- ❑ Yes, Cuban

What's your race? Select all that apply.

- ❑ American Indian or Alaska Native
- ❑ Chinese
- ❑ Japanese
- ❑ Other Asian
- ❑ Vietnamese
- ❑ Asian Indian
- ❑ Filipino
- ❑ Korean
- ❑ Other Pacific Islander
- ❑ White
- ❑ Black or African American
- ❑ Guamanian or Chamorro
- ❑ Native Hawaiian
- ❑ Somoan
- ❑ **I choose not to answer**

PART 7 **AGENT STATEMENTS**

I have reviewed the current health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs.

In addition to this policy I have sold this applicant the following policies that are still in force (attach additional sheet if necessary):

Policy # _____ Type _____ Effective date _____

Policy # _____ Type _____ Effective date _____

Policy # _____ Type _____ Effective date _____

I have also sold this applicant the following policies in the past five years that are no longer in force (attach additional sheet if necessary):

Policy # _____ Type _____ Effective date _____

Policy # _____ Type _____ Effective date _____

Policy # _____ Type _____ Effective date _____

_____ _____

Agent Signature **Today's Date**

Agent/Broker Name (please print) _____ _____ _____

First Name MI Last Name

Agent ID _____

Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield serves Western NY and is an independent licensee of the Blue Cross Blue Shield Association.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies. The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-833-735-4515 (TTY 711). 注意 : 如果您使用繁體中文, 您可以免費獲得語言援助服務。請致電 1-833-735-4515 (TTY 711)。

HIGHMARK
An Independent Licensee of the Blue Cross and Blue Shield Association

Discrimination is Against the Law

The Claims Administrator/Insurer complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity. The Claims Administrator/Insurer does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex assigned at birth, gender identity or recorded gender. Furthermore, the Claims Administrator/Insurer will not deny or limit coverage to any health service based on the fact that an individual's sex assigned at birth, gender identity, or recorded gender is different from the one to which such health service is ordinarily available. The Claims Administrator/Insurer will not deny or limit coverage for a specific health service related to gender transition if such denial or limitation results in discriminating against a transgender individual. The Claims Administrator/Insurer:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that the Claims Administrator/Insurer has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, including sex stereotypes and gender identity, you can file a grievance with: Civil Rights Coordinator, P.O. Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295, TTY: 711, Fax: 412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you. 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, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Pennsylvania, Delaware, West Virginia, and New York: 1-833-521-1424 (TTY: 711)

ATTENTION: If you speak English, assistance services, free of charge, are available to you. Call the number provided for your state of residence.

ATENCIÓN: Si habla español, tiene servicios de asistencia lingüística sin cargo. Llame al número correspondiente a su estado de residencia.

注意：如果您说中文，您可获得免费的语言援助服务。请拨打您所在州相应的电话号码。

توجه کنید: اگر به زبان فارسی صحبت می کنید، خدمات کمک زبانی به صورت رایگان در دسترس شما هستند. با شماره ارائه شده برای ایالت محل سکونتتان تماس بگیرید.

주의: 한국어을(를) 사용하는 경우, 언어 지원 서비스를 무료로 이용할 수 있습니다. 거주하시는 주의 전화 번호로 문의하십시오.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd nan lang gratis ki disponib pou ou. Rele nimewo telefòn ki koresponn ak Eta kote w rete a.

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ATTENZIONE: Se parla italiano, avrà a disposizione un servizio di assistenza linguistica gratuito. Chiami il numero fornito per il suo stato di residenza.

אכטונג: אויב איר רעדט אידיש, זענען שפראך הילף סערוויסעס, פריי פון אפצאל, אוועילעבל פאר אייך. רופט די נומער וואס איז צוגעשטעלט פאר אייער סטעיט וואו איר וואוינט.

মনোযোগ দিন: আপনি যদি বাংলা ভাষায় কথা বলেন, তাহলে আপনার জন্য বিনামূল্যে ভাষা সহায়তা পরিষেবা উপলব্ধ রয়েছে। আপনি বসবাসরত রাজ্যের জন্য দেওয়া নম্বরে ফোন করুন।

تنبيه: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية متاحة لك مجانًا. اتصل بالرقم المقدم للولاية التي تقيم فيها.

UWAGA: jeżeli posługuje się Pan/Pani językiem polsku, udostępniamy bezpłatne usługi wsparcia językowego. Prosimy zadzwonić pod numer podany dla stanu, w którym Pan/Pani mieszka.

ATTENTION : si vous parlez français, des services d'assistance linguistique sont disponibles gratuitement. Appelez le numéro de téléphone pour votre État de résidence.

توجہ دیں: اگر آپ اردو بولتے ہیں، تو لسانی مدد کی خدمات آپ کے لیے مفت دستیاب ہیں۔ اپنی رہائش والی ریاست کے لیے فراہم کردہ نمبر پر کال کریں۔

CHÚ Ý: Nếu quý vị nói Tiếng Việt, dịch vụ hỗ trợ ngôn ngữ miễn phí được cung cấp sẵn cho quý vị. Gọi số được cung cấp cho tiểu bang cư trú của quý vị.

PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo ng tulong sa wika nang walang bayad. Tawagan ang numerong ibinigay para sa estadong tinitirhan mo.

ΠΡΟΣΟΧΗ: Αν μιλάτε Ελληνικά, έχετε πρόσβαση σε δωρεάν υπηρεσίες γλωσσικής βοήθειας. Καλέστε τον αριθμό που παρέχεται για την περιοχή σας.