HIGHMARK®

AGENT & OFFICE USE ONLY	
Date Received:	Effective Date:
Agent Name:	Agent NPN:

In which channel was this application received?

❑ Face to Face Consultation ❑ Medicare Options Seminar
❑ Highmark Direct Store ❑ Member Benefits Forum
❑ Pre-set Home Visit ❑ Other

APPLICATION FOR HIGHMARK MEDICARE SUPPLEMENT INSURANCE PLANS

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.

SECTION I: APPLICANT INFORMATION

First Name	Middle Initial	Last Name			Suffix
Permanent Address (PO Box is not allowed)	Apt#	City	State	Zip	County of Residence
Mailing Address (if different)	Apt#	City	State	Zip	
Birthdate MM/DD/YYYY	Gender ❑ Male ❑ Female				
Preferred Telephone Number ❑ Home ❑ Mobile	Email Address				

Please provide your Medicare information below as shown on your red, white and blue Medicare Health Insurance card.

Name (as it appears on your Medicare card):		
Medicare Number	Part A (Hospital) Effective Date / /	Part B (Medical) Effective Date / /

SECTION II: PLAN SELECTION

Please indicate your plan choice below:

❑ Plan A ❑ Plan F High Deductible*
❑ Plan B ❑ Plan G
❑ Plan C* ❑ Plan N
❑ Plan F*

*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: / /

SECTION III: 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.

SECTION IV. APPLICATION STATEMENTS FOR MEDICARE SUPPLEMENT PROGRAM

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.

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 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
- ❑ Samoan
- ❑ **I choose not to answer**

THIS SECTION TO BE COMPLETED BY INSURANCE BROKER OR AGENT ONLY

A. List any other health insurance policies you have sold to this applicant which are still in force: _____

_____

B. List any other health insurance policies you have sold to this applicant in the past five years which are no longer in force:

_____

Signature of Agent or Broker _____ Date _____

Agency Name and Number _____

Phone #: ( ) _____

❑ 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.

FOR OFFICE USE:

_____

_____

_____

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INSTRUCTIONS FOR MAILING IN APPLICATION

Please review this checklist before you mail your application:

- ❑ Have you completed all required sections of the application form?
- ❑ Are your name and address written correctly on the application form?
- ❑ Have you attached your Certificate of Prior Creditable Coverage or your previous plan's letter of termination? (if applicable)
- ❑ Have you signed and dated your application?
- ❑ Have you attached the applicant's Power of Attorney or documentation of Legal Guardianship? (if applicable)

Return your completed application to us.

Use the envelope provided or mail to:

Highmark Blue Cross Blue Shield
PO Box 4208
Buffalo, NY 14240-98006

1-866-456-8140 (TTY 711)

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)。

Discrimination is Against the Law

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, including sex stereotypes and gender identity. The Plan 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 Plan 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 Plan 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 Plan:

- 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 Plan 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 of Civil Rights Complaint Portal, available at 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
Phone: 1-800-368-1019, 800-537-7697 (TDD)

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

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Pennsylvania, Delaware, West Virginia, and New York: 1-844-679-6930 (TTY:711)

ATTENTION: If you speak English, free language translation and interpretation services are available to you. Appropriate auxiliary aids and services (such as large print, audio, and Braille) to provide information in accessible formats are also available free of charge.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de traducción e interpretación de idiomas. También hay disponibles ayudas y servicios auxiliares adecuados (como letra grande, audio y Braille) para proporcionar información en formatos accesibles sin cargo.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Übersetzungs- und Dolmetscherdienste zur Verfügung. Außerdem sind kostenlos entsprechende Hilfsmittel und Dienstleistungen (wie Großdruck, Audio und Blindenschrift) zur Bereitstellung von Informationen in barrierefreien Formaten erhältlich.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis tradiksyon ak entèpretasyon aladispozisyon w gratis nan lang ou pale a. Èd ak sèvis siplemantè apwopriye (tèlke gwo lèt, odyo, Braille) pou bay enfòmasyon nan fòma aksesib yo disponib gratis tou.

ВНИМАНИЕ: Если Вы говорите на русском языке, Вам доступны бесплатные услуги перевода на другой язык. Также предоставляется дополнительная бесплатная помощь и услуги отображения информации в доступных форматах (например, крупным шрифтом, шрифтом Брайля или в виде аудиозаписи).

ATTENZIONE: se parla italiano, sono disponibili servizi gratuiti di traduzione e interpretariato. Sono inoltre disponibili gratuitamente adeguati supporti e servizi ausiliari (ad esempio caratteri grandi, audio e Braille) per fornire informazioni in formati accessibili.

ATTENTION : si vous parlez français, des services de traduction et d'interprétation gratuits sont à votre disposition. Vous pouvez aussi bénéficier gratuitement de l'accès à des outils et services auxiliaires appropriés (affichage en gros caractères, audio et le braille) dans des formats accessibles.

ÀKÍYÈSÍ: Tí o bá nsọ èdè Yorùbá, àwọn iṣẹ ìtumọ ati òǵbufọ èdè wà ní àrọwọtó lọ́fẹ̀ẹ́ fún ọ. Awọn iṣẹ ìtọ́jú ati ìrànlọ́wọ́ tó yẹ (bíi titẹwé nla, gbigbọ ohùn, ati ìwé afọ́jú) lati pèsè iwifúnni ni awọn ọna ìráàyè si wà pẹlu lọ́fẹ̀ẹ́.

אכטונג: אויב איר רעדט אידיש, קענט איר באקומען שפראך איבערזעצונג און דאלמעטשונג סערוויסעס פריי פון אפצאל. געהעריגע הילפסמיטלען און סערוויסעס (אזויווי גרויסע דרוק, אודיא און ברעיל) צו צושטעלן אינפארמאציע אין צוגענגליכע פארמאטן זענען אויך דא צו באקומען פריי פון אפצאל.

تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات الترجمة التحريرية والترجمة الفورية مجانًا. تتوفر أيضًا الوسائل والخدمات المساعدة المناسبة (مثل الطباعة الكبيرة، والوسائل الصوتية، وطريقة برايل) لتقديم المعلومات بتنسيقاتٍ يمكن الوصول إليها من دون أي تكلفة.

注意：如果您说中文，我们将为您提供免费的语言翻译和口译服务。此外，我们还免费提供相应的辅助工具和服务（如大字体、音频和盲文），以便您获取无障碍格式的信息。

ધ્યાન આપશો: જો તમે ગુજરાતી બોલતા હોવ, તો તમારા માટે નિઃશુલ્ક ભાષા અનુવાદ અને ઇન્ટરપ્રિટેશન સેવાઓ ઉપલબ્ધ છે. સુલભ ફોર્મેટમાં માહિતી પૂરી પાડવા માટે યોગ્ય સહાયક સાધનસામગ્રી અને સેવાઓ (જેમ કે મોટી પ્રિન્ટ, ઓડિયો અને બ્રેઇલ) પણ નિઃશુલ્ક ઉપલબ્ધ છે.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi có dịch vụ biên dịch và phiên dịch ngôn ngữ miễn phí dành cho quý vị. Chúng tôi cũng cung cấp miễn phí các dịch vụ và hỗ trợ bổ sung thích hợp (như chữ in lớn, tệp âm thanh và chữ nổi) để cung cấp thông tin ở các định dạng dễ tiếp cận.

ध्यान दिनुहोस्: यदि तपाईं नेपाली बोल्नुहुन्छ भने, तपाईंलाई निःशुल्क भाषा अनुवाद र दोभासे सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक प्रविधि र सेवाहरू (जस्तै ठूलो प्रिन्ट, अडियो र ब्रेल) पनि निःशुल्क उपलब्ध छन्।

कृपया ध्यान दें: यदि आप हिंदी भाषा बोलते हैं, तो आपके लिए मुफ़्त भाषा अनुवाद और व्याख्या संबंधी सेवाएं उपलब्ध हैं। एक्सेस करने योग्य फ़ॉर्मेट में सूचना उपलब्ध कराने के लिए उपयुक्त सहायक सामग्री और सेवाएं (जैसे बड़े प्रिंट, ऑडियो और ब्रेल) भी निःशुल्क उपलब्ध हैं।

주의: 한국어를 사용하는 경우 무료 언어 번역 및 통역 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공받을 수 있는 적절한 보조 수단 및 서비스(예: 큰 활자, 오디오, 점자)도 무료로 이용할 수 있습니다. 도움이