HIGHMARK® Delaware

Highmark Blue Cross Blue Shield Delaware
Attn: Enrollment Services
P.O. Box 8868
Wilmington, DE 19899-8868

MEDIGAP BLUE APPLICATION

PART I. GENERAL INFORMATION

APPLICATION INFORMATION

Print Name: First Middle Last

Address: Street City State DE Zip Code

Mailing Address: (If different) Street City State DE Zip Code

Birth Date: / / Current Age: Social Security Number: – – Gender: ☐ Male ☐ Female

Telephone Number: ( ) Email Address:

MEDICARE INFORMATION

To apply for a Medigap Blue policy with Highmark Blue Cross Blue Shield Delaware, you must be a Delaware resident and enrolled in Medicare A and B as of the date your policy begins. You must maintain Medicare Part A and B while you are a member.

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

Medicare Claim Number	Part A (Hospital) Effective Date	Part B (Medical) Effective Date

Select a Plan: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan F High Deductible ☐ Plan G ☐ Plan N

Select an Effective Date: 1st of _____ (specify month)

For an additional monthly fee, would you like to enroll in the optional Whole Health Balance Program, which provides coverage for hearing, vision, dental and fitness? (See Program Description for details) ☐ Yes ☐ No

PART II. HEALTH QUESTIONS

1. By the effective date of this policy, will you be age 65 or older? ☐ Yes ☐ No
2. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
3. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
4. Are you guaranteed acceptance into certain Medicare Supplement plans based on the conditions listed in the brochure, "Important Information About Your Rights to Guaranteed Issue of Medicare Supplement Policies"? ☐ Yes ☐ No
5. Have you used any form of tobacco in the last 12 months? ☐ Yes ☐ No
6. If you are under age 65, did you enroll in Medicare due to End Stage Renal Disease? ☐ Yes ☐ No

If the answer to questions 2, 3 or 4 above is "Yes" and you meet the eligibility criteria in the Medicare Information section, please skip to Part IV. You do not need to answer the questions in the Statement of Health section below and on page 2.

PART III. STATEMENT OF HEALTH

Current Height : _____ feet _____ inches Current Weight: _____ pounds

1. Are you currently bedridden, hospitalized, or residing in a nursing home, convalescent or assisted living facility? ☐ Yes ☐ No
2. Has your physician advised you to have surgery, therapy, tests or treatment in the past two years which you have not had? ☐ Yes ☐ No
3. Do you need supervision, assistance or a wheelchair for any activities of daily living, such as eating, dressing, bathing or walking? ☐ Yes ☐ No

If the answer to questions 1, 2 or 3 above is "Yes", please explain below. Please continue on a separate sheet if necessary:

_____

4. Have you been diagnosed or treated for any of the following conditions in the last five years? Do not include any genetic information, such as family medical history or any information related to genetic testing, services or counseling.

ENR-182 (R5-18)

STATEMENT OF HEALTH, CONTINUED

a. AIDS, HIV or other immune diseases	☐ Yes ☐ No	i. Heart attack, heart disease	☐ Yes ☐ No
b. Alcohol or Substance abuse	☐ Yes ☐ No	j. Joint Replacement	☐ Yes ☐ No
c. Alzheimer's or dementia	☐ Yes ☐ No	k. Kidney disease, dialysis, renal failure	☐ Yes ☐ No
d. Arthritis - disabling	☐ Yes ☐ No	l. Liver (chronic) disorder, cirrhosis, hepatitis C	☐ Yes ☐ No
e. Bone Marrow or other major organ transplant	☐ Yes ☐ No	m. Parkinson's, Multiple Sclerosis, ALS (Lou Gehrig's disease), Systemic Lupus, Muscular Dystrophy	☐ Yes ☐ No
f. Cancer (exclude basal, squamous cell)	☐ Yes ☐ No	n. Psychiatric illness or history requiring hospitalization	☐ Yes ☐ No
g. Diabetes (using insulin)	☐ Yes ☐ No	o. Stroke or paralysis	☐ Yes ☐ No
h. Emphysema, COPD or lung disorder	☐ Yes ☐ No		

4b. If you answered " Yes," to any question above, please provide requested information below:

Corresponding Letter of Condition Listed Above	Date Condition Started	Date of Last Treatment	Describe Results / Findings / Status	Full Name of Treating Physician

5. In the last 12 months, have you taken or been medically advised to take any prescription medications? ..... ☐ Yes ☐ No

5b. If you answered "Yes," please provide details below. Please list additional medications on a separate sheet if necessary.

Medication	Are You Still Taking This Medication?	Dosage	Frequency	Condition for which prescribed
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			
	☐ Yes ☐ No			

PART IV. EXISTING COVERAGE INFORMATION

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement 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 prior insurer with your application.**

Please answer all questions to the best of your knowledge.

1. Do you have another Medicare Supplement policy in force? ..... ☐ Yes ☐ No
   - If yes, with what company and what plan do you have?_____
   - If yes, do you plan to replace your current Medicare supplement policy with this policy? ..... ☐ Yes ☐ No
2. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (e.g., a Medicare Advantage plan, or a Medicare HMO or PPO)? ..... ☐ Yes ☐ No
   - If yes, provide the Start Date ____/____/____ and End Date ____/____/____ (leave blank if still covered)
   - If you are still covered under this Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ..... ☐ Yes ☐ No
   - Was this your first time in this type of Medicare plan? ..... ☐ Yes ☐ No
   - Did you drop a Medicare Supplement policy to enroll in this Medicare plan? ..... ☐ Yes ☐ No
3. Have you had coverage under any other health insurance plan within the past 63 days (e.g., an employer, union, or individual plan)? ..... ☐ Yes ☐ No
   - If yes, what kind of policy?_____
   - What are your dates of coverage under the other policy? Start Date ____/____/____ End Date ____/____/___ (leave blank if still covered)

4. 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, will Medicaid pay your premiums for this Medicare Supplement policy? ..... ☐ Yes ☐ No
   - If yes, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ..... ☐ Yes ☐ No

PART V. PAYMENT

1. **Select a Billing Option:** ☐ Monthly ☐ Quarterly
2. Payment is not required. You will be billed. If you choose to include payment for premiums, please enclose a check or money order made payable to Highmark DE.

PART VI. CUSTOMER INFORMATION

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 the Medicare supplement policy 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). Call ELDERinfo at 800-336-9500 or 302-674-7364.

PART VII. TERMS OF AGREEMENT (PLEASE READ CAREFULLY, THEN SIGN.)

I understand that there is a six-month waiting period before benefits are paid for any preexisting condition I may have; however, I understand I may have the ability to reduce or eliminate this waiting period. I will be credited for the time I have been continuously covered if I am:

- applying for a change in my current Highmark DE plan; or
- replacing another company's or another Blue Cross and Blue Shield Plan's coverage.

In that case, I must provide a Certificate of Coverage from this carrier.

I understand that a preexisting condition is any disease, condition or ailment for which I was treated or for which I received medical advice during the six months before the date my coverage begins with Highmark DE.

I acknowledge that certain personally identifiable information about me (collectively, "Personal Information") is subject to various statutory privacy standards, including, but not limited to, state insurance regulations implementing Title V of the Gramm-Leach-Bliley Act and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations adopted thereunder by the Department of Health and Human Services (45 CFR Parts 160, 162, 164). In accordance with those standards, Highmark DE may use and disclose Personal Information as permitted or required by law, and to facilitate payment, treatment and health care operations as described in its Notice of Privacy Practices ("NPP").

I understand that a copy of Highmark's current NNP is available on Highmark's Web site, or from the Highmark Privacy Department.

I acknowledge that no right whatsoever is created by this Application, and that I will not be covered by Highmark DE unless and until this Application for coverage is approved and I have been provided with an Effective Date and Identification Number, and only as long as I continue to qualify under the terms of this policy with Highmark DE, including timely payment of premiums.

PART VIII. STATEMENTS OF UNDERSTANDING AND AUTHORIZATION (PLEASE READ CAREFULLY, THEN SIGN.)

I understand the insurance producer cannot approve coverage. This Application and the payment of the initial subscription rate does not guarantee that coverage will be provided. I further understand coverage, if provided, will not take effect until issued by Highmark and that the actual subscription rate will not be determined until coverage is issued. I understand the person discussing Medigap Blue plan options with me is either employed by or contracted with Highmark DE and may be entitled to receive compensation based on my enrollment in a plan.

I understand that I am eligible for coverage only if I have both Parts A and B of Medicare and am a Delaware resident. If for any reason I am not enrolled in Medicare Part A or B, Highmark DE has the right to deny my application. If for any reason I become ineligible for Medicare A and B at some future date, I agree to notify Highmark DE immediately.

I understand that when I purchase this coverage, any other direct pay Highmark DE coverage I may have in effect will be cancelled as of the effective date of the Medigap Blue coverage.

I understand that my coverage can only be cancelled if I do any of the following:

- request cancellation in writing,
- fail to pay my premium,
- knowingly misrepresent or furnish inaccurate information on this application, or
- fail to keep Parts A and B of Medicare.

I also understand that if any changes in my health status occur prior to the effective date, I will promptly notify Highmark DE.

I hereby authorize the Centers for Medicare and Medicaid Services (CMS) to furnish Highmark DE medical or other information acquired by it under the Title VII program (Medicare) to the extent necessary to process any claim under the Highmark DE Medigap Blue Agreement in effect with Highmark DE.

I authorize any medical professional, hospital, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medically-related facility, governmental agency or other person or firm, to disclose to Highmark DE or its authorized representative, information (including copies of records) concerning advice, care or treatment provided to me. That information may include, without limitation, information relating HIV/AIDS, mental health, or abuse of drugs or alcohol. In addition, I authorize Highmark DE to use its own records for information. I understand that such information will be used by Highmark DE to evaluate my application for health coverage, to decide whether or not to offer me coverage, and to determine whether I am eligible for benefits. I understand information obtained with my authorization may be re-disclosed by Highmark DE as permitted or required by law and that upon such re-disclosure, it may no longer be longer be protected by federal privacy laws. I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid for two years from the date signed unless (a) revoked by me in writing, which I may do at any time, or (b) Highmark DE declines this application. Any revocation will not affect the activities of Highmark DE prior to the date such revocation is received by Highmark DE.

All the information I have given on this application is true and complete to the best of my knowledge and belief. If the information is false, my coverage is void.

I hereby acknowledge that I have received an Outline of Medicare Supplement Coverage and the Guide to Health Insurance for People with Medicare.

I hereby acknowledge that I have read and accept the Statement of Understanding and Authorization.

Signature _____ **Date** _____ / _____ / _____

Power of Attorney _____ Phone Number _____ Date _____ / _____ / _____

PART VIIII. INSTRUCTIONS (BEFORE MAILING PLEASE BE SURE THAT THE FOLLOWING HAS BEEN COMPLETED)

- Answer all questions on this application (incomplete applications will be returned)
- Sign and date the application
- Include payment (optional)
- Submit a Certificate of Coverage to reduce the preexisting waiting period if you had prior coverage with another carrier (excluding Highmark DE and Medicare)
- Call the Highmark DE Marketing Department at 888-692-5830 if you have any questions about completing this application

Important Note: As of January 1, 2012, the definition of spouse includes a civil union partner.

Thank you for selecting Highmark DE as your Medicare Supplement carrier. We look forward to serving you!

For Broker Use Only:

1) List policies sold to applicant that are still in force:

Name of Insurer	Type of Policy

2) List policies sold to applicant in the past five years that are no longer in force:

Name of Insurer	Type of Policy
Broker Name/Number	GA Name/Number

HIGHMARK. Delaware

An Independent Licensee of the Blue Cross and Blue Shield Association

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. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. 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, 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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-844-679-6930.

ATENCIÓN: Si usted habla español, servicios de asistencia lingüística, de forma gratuita, están disponibles para usted. Llame al 1-844-679-6930.

请注意：如果您说中文，可向您提供免费语言协助服务。

請致電 1-844-679-6930 。

ATTENTION: Si c'est créole que vous connaissez, il y a un certain service de langues qui est gratis et disponible pour vous-même. Composez le 1-844-679-6930.

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ધ્યાન આપશો: જો તમે ગુજરાતી ભાષા બોલતા હો, તો તમને ભાષા સહાયતા સેવાઓ, મફતમાં ઉપલબ્ધ છે. 1-844-679-6930 નંબર પર ફોન કરો.

ATTENTION: Si vous parlez français, les services d'assistance linguistique, gratuitement, sont à votre disposition. Appelez au 1-844-679-6930.

알림: 한국어를 사용하시는 분들을 위해 무료 통역이 제공됩니다. 1-844-679-6930 로 전화.

ATTENZIONE: se parla italiano, per lei sono disponibili servizi di assistenza linguistica a titolo gratuito. Chiamare l'1-844-679-6930.

CHÚ Ý: Nếu quý vị nói tiếng Việt, chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Xin gọi số 1-844-679-6930.

ACHTUNG: Wenn Sie Deutsch sprechen, steht Ihnen unsere fremdsprachliche Unterstützung kostenlos zur Verfügung. Rufen Sie 1-844-679-6930.

ATENSYON: Kung nagsasalita ka ng Tagalog, may makukuha kang mga libreng serbisyong tulong sa wika. Tumawag sa 1-844-679-6930.

ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवा उपलब्ध है। 1-844-679-6930 पर फ़ोन करें.

توجہ فرمائیں: اگر آپ اردو بولتے ہیں، زبان معاونت سروس، مفت میں آپ کے لیے دستیاب ہے۔ 1-844-679-6930 پر کال کریں۔

تنبيه: إذا كنت تتحدث اللغة العربية، فهناك خدمات المعاونة في اللغة المجانية متاحة لك. اتصل على الرقم 1-844-679-6930.

గమనిక: మీరు తెలుగు మాట్లాడితే, లాంగ్వేజ్ అసిస్టెన్స్ సర్వీసెస్, ఛార్జి లేకుండా, మీకు అందుబాటులో ఉన్నాయి. కాల్ చేయండి 1-844-679-6930.

Aandacht: Indien u Nederlands spreekt, is de taaladviesdienst gratis beschikbaar voor u. Bel 1-844-679-6930.

ВНИМАНИЕ: Если вы говорите по-русски, вы можете воспользоваться бесплатными услугами языковой поддержки. Звоните 1-844-679-6930.

ATENÇÃO: Se a sua língua é o português, temos atendimento gratuito para você no seu idioma. Ligue para 1-844-679-6930.

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń 1-844-679-6930.

注：日本語が母国語の方は言語アシスタンス・サービスを無料でご利用いただけます。1-844-679-6930 を呼び出します。

توجه: اگر شما به زبان فارسی صحبت می کنید، خدمات کمک زبان رایگان با تماس با شماره 1-844-679-6930. موجود است.

BAA ÁKONÍNÍZIN: Diné k'ehgo yáníłti'go, language assistance services, éí t'áá níík'eh, bee níká a'doowoł, éí bee ná'ahóót'i'. Kojį' hodíilnih 1-844-679-6930.