Blue Cross and Blue Shield of New Mexico

Application for Medicare Supplement Policies

(and Plan and Address Changes)

Read the entire application. Indicate selections in boxes with a check mark ☑.

Action

- ☐ Enroll in Medicare Supplement Plan
- ☐ Change Plan (currently a member)
- ☐ Change Address

Select Plan

☐ Plan A ☐ Plan B ☐ Plan F

Select Desired Effective Date

See related text on page 3 of this form.

☐ January	☐ July
☐ February	☐ August
☐ March	☐ September
☐ April	☐ October
☐ May	☐ November
☐ June	☐ December

Tell Us About Yourself

NAME (Last, First, Middle Initial) ☐ Mr. ☐ Miss ☐ Ms. ☐ Mrs.			BIRTH DATE (Mo, Day, Yr)
HOME ADDRESS (Street) (new address if giving address change)			AGE
CITY NM		ZIP CODE	SEX ☐ Male ☐ Female
SOCIAL SECURITY #	HOME PHONE (505)	WEIGHT	HEIGHT

Medicare Information

You must have Medicare Part A and Medicare Part B coverage and be age 65 or older to enroll. Please give your Medicare information as shown on your red, white, and blue card.

HEALTH INSURANCE CLAIM NUMBER	MEDICARE HOSPITAL (PART A) EFFECTIVE DATE	MEDICARE MEDICAL (PART B) EFFECTIVE DATE

FOR OFFICE USE ONLY	FOR BROKER USE ONLY	
☐ Approved Effective Date ___________ ☐ Rejected — medical history ☐ Application pending medical information	Broker Name ____________________ Broker Number ____________________ Phone # ____________________	Broker Address ____________________ ____________________ ____________________

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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 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.
4. The benefits and premiums under your Medicare Supplement policy can be suspended for 24 months, if requested, during your entitlement to benefits under Medicaid. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
5. Counseling services may be available in New Mexico 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).

Questions

To the best of your knowledge:

1. Do you have another Medicare Supplement or a Medicare Advantage (Medicare HMO or Medicare PPO) policy in force? .... ☐ **Yes** ☐ **No**

   a. If so, with which company? ____________________________________

   b. If so, do you intend to replace your current Medicare Supplement or Medicare Advantage (HMO or PPO) policy with this policy (certificate)? . ☐ **Yes** ☐ **No**

2. Do you have any other health insurance coverage that provides benefits similar to this Medicare Supplement policy? .... ☐ **Yes** ☐ **No**

   a. If so, with which company? ____________________________________

   b. What kind of policy (e.g., carve out, complementary)? ______________

NOTE: If you checked one or more YES boxes in questions 1 or 2 above, you must fill out and submit two additional forms (enclosed) with this application:

- Other Coverage Questionnaire
- Notice to Applicant Regarding Replacement of Medicare Supplement Insurance

3. Are you covered for medical assistance through the state Medicaid program:

   a. As a Specified Low-Income Medicare Beneficiary (SLMB)?..................... ☐ **Yes** ☐ **No**

   b. As a Qualified Medicare Beneficiary (QMB)? .... ☐ **Yes** ☐ **No**

   c. For other Medicaid benefits? .... ☐ **Yes** ☐ **No**

Statement of Health

You do ***not*** have to answer the following health questions if you meet these criteria: 1) you are age 65 or older, and 2) you are applying for coverage within six months of enrolling in Medicare Part B. If you do not meet these criteria, you must complete this section. ***A single YES answer to questions 1-4 will automatically make you ineligible for this coverage.***

1. Are you currently hospitalized, residing in a nursing home, enrolled in a hospice program, or expecting to enter a hospital, nursing home, or hospice program in the next 6 months? .... ☐ **Yes** ☐ **No**

2. Do you have surgery pending, or have you been advised by a doctor in the past year that surgery is needed and not had the surgery? .... ☐ **Yes** ☐ **No**

3. Are you currently bedridden, or using a wheelchair or walker? .... ☐ **Yes** ☐ **No**

4. Have you been diagnosed or treated for any of the following conditions within the last 3 years?

- **a.** Cancer (other than skin cancer) .... ☐ **Yes** ☐ **No**
- **b.** Heart Disease .... ☐ **Yes** ☐ **No**
- **c.** Alcohol/Chemical Dependency .... ☐ **Yes** ☐ **No**
- **d.** Stroke or Paralysis .... ☐ **Yes** ☐ **No**
- **e.** Diabetes (using insulin) .... ☐ **Yes** ☐ **No**
- **f.** Kidney Disease/Dialysis .... ☐ **Yes** ☐ **No**
- **g.** Emphysema/Lung Disorder .... ☐ **Yes** ☐ **No**
- **h.** Cirrhosis/Liver Disorder .... ☐ **Yes** ☐ **No**
- **i.** HIV/AIDS .... ☐ **Yes** ☐ **No**
- **j.** Parkinson's Disease .... ☐ **Yes** ☐ **No**
- **k.** Alzheimer's Disease .... ☐ **Yes** ☐ **No**
- **l.** Multiple Sclerosis or Muscular Dystrophy .... ☐ **Yes** ☐ **No**

5a. Are you currently taking any prescription drugs or have you taken any prescriptions for more than 30 days during the past year? .... ☐ **Yes** ☐ **No**

b. Please complete the following information for prescription drugs you are currently taking or have taken for more than 30 days in the last year (attach separate sheet if needed):

NAME OF MEDICATION	DOSAGE (example: 4 mg tablet 2 times/day)	REASON FOR TAKING MEDICATION

Important: Please Read and Sign

Effective Date

I understand that BCBSNM shall have sixty (60) days from receipt of this application to review it, and if the application is not approved in writing, it shall be deemed to have been declined, and any monies submitted shall be returned. If the application is approved, the effective date of membership will be the 1st of the month following the date of approval. I understand that if my application is not approved, Blue Cross and Blue Shield of New Mexico is not required to disclose the reason(s) for nonacceptance.

Pre-Existing Conditions Limitation

I understand that my coverage may be subject to a pre-existing conditions limitation. See the enclosed “Other Coverage Questionnaire.”

Certify, Understand, and Acknowledge

I certify that the information contained in this application is true and correct to the best of my knowledge and belief. I authorize the release of Medicare claims information to Blue Cross and Blue Shield of New Mexico to allow payment of any supplemental benefit. I understand that this application shall become part of the contract between Blue Cross and Blue Shield of New Mexico and myself and that any misstatements contained herein shall void the membership Certificate.

I understand that Blue Cross and Blue Shield of New Mexico’s use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

I acknowledge that I have received the Outline of Medicare Supplement Coverage.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

SIGN BELOW (Must be signed by the applicant): **DATE:**

____ ____________________

Incomplete Applications will be Returned

Have you signed and dated the application?

If applicable:

- Have you completed the Statement of Health (within the application)?
- Have you completed and enclosed the “Other Coverage Questionnaire” along with “Certificate(s) of Creditable Coverage”?

Mail to:

Blue Cross and Blue Shield of New Mexico
Individual Product Administration
P.O. Box 1711
Chicago, IL 60690-1711

For additional information call 1-800-307-8144.