Missouri Valley
LIFE AND HEALTH
INSURANCE COMPANY

Medicare Supplement Application

BlueKC.com • One Pershing Square, 2301 Main, P.O. Box 419169, Kansas City, MO 64141-6169 • 816-395-2222

NOTE: IF YOUR SPOUSE WOULD LIKE TO APPLY, A SEPARATE APPLICATION MUST BE COMPLETED

☐ CHECK IF ELIGIBLE FOR MEDICARE DUE TO A DISABILITY

REQUESTED EFFECTIVE DATE: _____

NOTE: This Medicare Supplement product is offered by Missouri Valley Life and Health Insurance Company (MVLH), a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City (Blue KC).

I Personal Details

1. LAST NAME FIRST NAME MIDDLE INITIAL SUFFIX			2. DATE OF BIRTH	3. GENDER ☐ Male ☐ Female
4. SOCIAL SECURITY NUMBER				
5. *HOME ADDRESS (Street Number and Name, Apt. Number)				
6. CITY	7. STATE	8. ZIP	9. COUNTY	
10. ALTERNATE ADDRESS* (Please indicate only one): ☐ Billing Only ☐ Billing and All Correspondence				
11. CITY	12. STATE	13. ZIP	14. COUNTY	
15. DAYTIME PHONE**	16. HOME PHONE	17. E-MAIL ADDRESS***		

* Home address denotes applicant's permanent legal address and must be completed. Alternate address should be selected if billing, I.D. cards, etc. should go to a different address.

** By including your phone number, you agree to be contacted by Us at either the primary or secondary phone number provided. If the phone number you provided is a cellular phone number any calls may subject you to charges by your cellular carrier and/or service provider as provided in your wireless rate plan (contact your carrier for pricing plans and details).

*** We may use this email address to provide documents, materials and other notices related to coverage.

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

II Medicare Information

Please complete the information below as it appears on your Medicare card. Or, attach a copy of your Medicare card or your Letter of Verification from the Social Security or Railroad Retirement Office. We cannot consider this form complete until we have obtained this information.

1. Name_____

2. MEDICARE OR RAILROAD RETIREMENT BOARD NUMBER_____

3. IS ENTITLED TO: EFFECTIVE DATE
HOSPITAL INSURANCE (PART A) _____
MEDICAL INSURANCE (PART B) _____

III Coverage Selection: Medical

MEDICARE SUPPLEMENT

☐Plan A ☐Plan G

☐Plan F* ☐Plan N

* Only beneficiaries who were either entitled to Medicare due to disability/ESRD, or who turned 65, prior to January 1, 2020 are eligible to select a Plan F policy.

Were you Age 65 and eligible for Medicare prior to 1/1/2020? ☐ YES ☐ NO

Were you entitled to Medicare prior to 1/1/2020 due to disability/ESRD? ☐ YES ☐ NO

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

IV Other Insurance Information

To the best of your knowledge, please answer the following questions:

☐ YES	☐ NO	1. A. Did you turn age 65 in the last 6 months?
☐ YES	☐ NO	B. Will you be turning 65 in the next 6 months?
☐ YES	☐ NO	C. Did you enroll in Medicare Part B in the last 6 months?
☐ YES	☐ NO	D. If yes, what is the effective date? Date: _____
☐ YES	☐ NO	E. Are you enrolling in Medicare Part B in the next 6 months?
		F. If yes, what is the effective date? Date:_____
☐ YES	☐ NO	2. A. Are you covered for medical assistance through the state Medicaid Program? [NOTE TO APPLICANT: If you are participating in a "Spenddown Program" and have not met your "Share of Cost," please answer NO to this question.]
☐ YES	☐ NO	B. If yes, will Medicaid pay your premiums for this Medicare supplement policy?
☐ YES	☐ NO	C. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
☐ YES	☐ NO	3.A. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below and provide applicable policy and company information. If you are still covered under this plan, leave "END" blank. Start _____ End _____ Company: _____ Plan ID#: _____ When was your policy effective: _____ Co. Phone Number: _____
☐ YES	☐ NO	B. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?
☐ YES	☐ NO	C. Was this your first time in this type of Medicare Plan?
☐ YES	☐ NO	D. Did you drop a Medicare supplement policy to enroll in the Medicare plan? NOTE: It is your responsibility to disenroll from your existing Medicare Advantage plan.
☐ YES	☐ NO	4. A. Do you have another Medicare supplement policy in force?
		B. If so, with what company and what plan do you have? Company: _____ Plan ID#: _____
		C. When was your policy effective: _____ Co. Phone Number: _____
☐ YES	☐ NO	D. If so, do you intend to replace your current Medicare supplement policy with this policy?
☐ YES	☐NO	5.A. Have you had coverage under Blue KC, MVLH or any other health insurance within the past 63 days? (For example, an employer, union or individual plan)
		B. If so, with what company and what kind of policy? Company: _____ Plan ID#: _____ Co. Phone Number: _____
		C. What are your dates of coverage under the other policy? If you are still covered underthe other policy, leave "END" blank? Start _____ End _____
☐ YES	☐NO	6. If you have dependents on your current Blue KC individual policy, do you want to continue coverage for the dependents?

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

V Required Notices

- You do not need more than one Medicare Supplement Policy.

- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement Policy.

- 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 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 the suspension.

- 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 ninety (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.

- 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).

- 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 insurance 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.

- This Medicare Supplement product is offered by Missouri Valley Life and Health Insurance Company, a wholly-owned subsidiary of Blue Cross and Blue Shield of Kansas City.

Applicant Information (Please provide again to assist in case pages become separated)
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VI Medical Questionnaire - Complete only if NOT applying during a GI or OE period.

Open Enrollment (OE) – A one-time only, 6-month period when federal law allows you to buy any Medicare Supplement policy you want that's sold in your state.

Guaranteed Issue (GI) – Guaranteed Issue rights are your rights to buy certain Medicare Supplement policies in certain situations outside of your Medicare Supplement Open Enrollment Period.

Guaranteed Acceptance – PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE

1. Are you applying for coverage during your Medicare Supplement Open Enrollment Period? ☐ YES ☐ NO
2. Have you lost, or are you losing or replacing, other health coverage which would qualify you for guaranteed issue? ☐ YES ☐ NO

If you answered Yes to either question, please proceed directly to Section VII.

GENETIC INFORMATION NONDISCRIMINATION ACT

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting "genetic information" for underwriting purposes. "Genetic information" includes your genetic test, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by the policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. Do not report genetic information on this form. However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

Height: _____ Weight: _____

☐ **YES**	☐ **NO**	1. Within the past three years have you had or been treated for a stroke, phlebitis, heart attack, chronic heart condition or congestive heart failure?
☐ **YES**	☐ **NO**	2. Have you ever had heart valve surgery, a pacemaker or other implanted cardiac device?
☐ **YES**	☐ **NO**	3. Within the past three years have you been diagnosed with or treated for any type of cancer, excluding common skin cancer?
☐ **YES**	☐ **NO**	4. Within the past three years have you been diagnosed with or treated for Parkinson's Disease, Alzheimer's Disease, Dementia or Bipolar disorder?
☐ **YES**	☐ **NO**	5. Have you ever been diagnosed or treated for emphysema, any chronic lung condition or use oxygen?
☐ **YES**	☐ **NO**	6. Have you had an amputation due to disease or trauma?
☐ **YES**	☐ **NO**	7. Any complications from diabetes including retinopathy, neuropathy, edema or kidney disease? Have you ever been advised to have dialysis of any kind?
☐ **YES**	☐ **NO**	8. Any treatment for severe disabling arthritis, fibromyalgia, myasthenia gravis, lupus, multiple sclerosis, amyothrophic lateral sclerosis (ALS), paralysis, joint replacement or organ transplant of any kind?
☐ **YES**	☐ **NO**	9. Ever been diagnosed or treated for drug or alcohol abuse, cirrhosis of the liver, HIV, AIDS or AIDS related complex (ACR)?
☐ **YES**	☐ **NO**	10. In the past 5 years, have you been advised to have surgery or treatment not yet performed?
☐ **YES**	☐ **NO**	11. Do you walk with a cane or walker, use a wheelchair or are you bedridden?
☐ **YES**	☐ **NO**	12. Have you been hospitalized, inpatient or outpatient within the last 2 years?
☐ **YES**	☐ **NO**	13. Are you currently taking any medications?

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

Question #	Type of Ailment or Diagnosis of Condition	Date of Condition	Date of Last Treatment	Date of Surgery	Prescription Drugs Being Taken	Name(s) and Address(es) of Physician(s)

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

VII Agreement and Acknowledgement

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Missouri Valley Life and Health has the right to reject my application and any premiums paid will be refunded. I understand and agree that any incorrect statements made by me in this application will invalidate my coverage and that all statements made by me will, in the absence of fraud, be deemed representations and not warranties. I realize that any fraudulent misrepresentation regarding the presence of preexisting impairments or disease will result in cancellation of my coverage retroactive to the effective date. This application is submitted subject to all the terms and conditions of the policy under which application is made. I hereby agree to accept all terms and conditions of the policy. I acknowledge that I have received an outline of coverage.

You agree that by checking "Yes" you consent and request that MVLH, our affiliates, and those acting on our or their behalf, may call or text you using an automated telephone dialing system and/or a prerecorded message. The types of calls or texts you may receive include advertisements or telemarketing messages concerning our or our affiliates' benefits and services. You understand that consent is not a condition of purchase. ☐ YES ☐ NO

Applicant's Signature:

Printed Name:

Date:

OFFICE USE ONLY

Date Received	**Effective Date**	**Pre-X Effective Date**	**Closed Date**
List Bill Number	**Class**	**Health Plan**	
Area/Issue Age	**Premium**	**Reason for Decline**	

VIII Applicant Representative

This is to be filled out when the individual filling out the application is either not the primary applicant or is below 18 years of age.

1. LAST NAME		2. DATE OF BIRTH	3. RELATIONSHIP TO APPLICANT
4. HOME ADDRESS (Street Number and Name, Apt. Number)			
5. CITY	6. STATE	7. ZIP	8. COUNTY
9. PRIMARY PHONE NUMBER			

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

Nondiscrimination Notice

DISCRIMINATION IS AGAINST THE LAW

Blue KC and MVLH comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue KC and MVLH do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue KC and MVLH:

- Provide 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)
- Provide 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 Customer Service, 844-395-7126 (Toll free), languagehelp@bluekc.com.

If you believe that Blue KC or MVLH 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 the Appeals Department, PO Box 419169, Kansas City, MO 64141-6169, 816-395-3537, TTY: 816-842-5607, APPEALS@bluekc.com. You can file a grievance in person or by mail, or email. If you need help filing a grievance, the Appeals Department 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.

Broker Representation (if applicable)

I represent that to the best of my knowledge all statements are complete and accurate.

Blue KC/MVLH Broker Number

REQUIRED

PRINTED BROKER'S NAME **BROKER SIGNATURE** **DATE**

TELEPHONE NUMBER **E-MAIL ADDRESS**

1. List any health insurance policies you have sold to the applicant which are still in force:

2. List any other health insurance policies you have sold to the applicant in the past five (5) years which are no longer in force:

Applicant Information (Please provide again to assist in case pages become separated)
LAST NAME: FIRST NAME:

Notice 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 insurance and replace it with a policy to be issued by MVLH. 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 new 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, AGENT, BROKER 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 premiums.

____ Fewer benefits and lower premiums.

____ My plan has outpatient prescription drug coverage and I am enrolling in Part D.

____Disenrollment from a Medicare Advantage Plan. Please explain reason for disenrollment.

____Other. (please specify) _____

Please read the required notice below. MVLH does not impose any pre-existing condition limitations, waiting periods, elimination periods or probationary periods.

1. 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.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

I represent that to the best of my knowledge all statements are complete and accurate.

Blue KC/MVLH Broker Number

REQUIRED IF APPLICABLE

PRINTED BROKER'S/AGENT'S/OTHER REPRESENTATIVE'S NAME	SIGNATURE*	DATE
PRINTED APPLICANT'S NAME	SIGNATURE	DATE

*Signature not required for direct response sales.

PAYMENT METHOD

Please remember to enclose correct premium payment. Make checks payable to BCBS of KC.

- With Electronic Funds Transfer, your premium is automatically deducted from your checking account every month.
- Your first premium will be processed immediately upon approval.
- Your premium will be paid automatically, on time, each and every month.
- **For future payments, your account will be drafted on the 5th of each month or next business day.**

☐ Please debit my account automatically each month for the full premium amount due.

NAME: SOCIAL SECURITY NO:

NAME OF BANK NAME ON ACCOUNT

ROUTING NUMBER (9 digit #) BANK ACCOUNT #

Yes, I want Electronic Funds Transfer.

SIGNATURE: DATE:

CREDIT CARD AUTHORIZATION: We offer the convenience of paying by credit card. Payment by credit card can be accepted for a payment of one or more premiums; or with your signed authorization, we can automatically charge your credit card for your full premium each month. To pay by credit card, select one of the following options *(all information must be complete for processing)*:

☐ Please charge my credit card automatically each month for the full premium amount due.
I understand that my credit card will be charged each month on the 5th day of the month or next business day.

Choose only one: ☐ Visa ☐ Master Card
Account Number: _____Expiration Date: _____ CVV Code: _____
Billing Address: _____
Account Name: _____Signature: _____
NOTE: To cancel your automatic credit card authorization, your request must be received 10 days prior to your credit card withdrawal date.

FOR AGENT USE ONLY

Agent's Full Name	Agent #	Telephone #
Address	City	State Zip
E-Mail Address		