Kansas City

An Independent Licensee of the Blue Cross and Blue Shield Association

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: ___________________

I Application Checklist

So that you can complete the application easily, be sure you have the following information available for each person applying for coverage: • Birth Date • Medicare Health Insurance card

1. Did an Agent assist you with shopping for a plan? ☐ Yes ☐ No

2. Please enter your Agent's Blue KC Broker number, and First and Last Name. Your agent should have provided you with this information. If you do not have this information, please select No for this question.
Blue KC Broker Number________________________________ First Name_________________________________
Last Name____ ☐ No

II Applicant Representative

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

1. LAST NAME FIRST NAME MIDDLE INITIAL SUFFIX	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			

III Medicare Information

Please provide the following information from your red, white and blue Medicare Card.

1. NAME OF APPLICANT	2. GENDER ☐ Male ☐ Female

3. MEDICARE IDENTIFICATION TYPE ☐ Medicare Number ☐ Railroad Retirement Board Number

4. MEDICARE OR RAILROAD RETIREMENT BOARD NUMBER____

5. To the best of your knowledge, are you enrolled in your State Medicaid Program? ☐ Yes ☐ No

6. If so, which programs? (Please check all that apply.) ☐ Specified Low Income Medicare Beneficiary (SLMB) ☐ Qualified Medicare Beneficiary (QMB) ☐ Program for All-Inclusive Care for the Elderly (PACE)

7. Will Medicaid pay your premiums for this Medicare Supplement policy? ☐ Yes ☐ No	8. MEDICAID NUMBER______________________________
8.NAME OF BENEFICIARY	9. IS ENTITLED TO: EFFECTIVE DATE HOSPITAL INSURANCE (PART A) ____________________ MEDICAL INSURANCE (PART B) ____________________

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

IV 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***	
18. HAVE YOU USED TOBACCO IN THE PAST?	19. PREFERRED METHOD OF COMMUNICATION ☐ Phone ☐ Mail ☐ Email		
20. WHAT IS THE BEST TIME TO REACH YOU? ☐ Daytime ☐ Evening ☐Night	21. RE-ENTER EMAIL ADDRESS		

NOTE: The following questions are optional. The following information may be used to communicate with you both in English and your language of Preference or disability needs, when available. The collection of this information will not determine eligibility, rating or claim payments.

22. ETHNICITY ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ I prefer not to answer	23. RACE ☐ Black or African ☐ White ☐ Asian ☐ Native Hawaiian or other Pacific Islander ☐ Other race ☐ I prefer not to answer
24. SPOKEN LANGUAGE OF PREFERENCE ☐ I prefer not to answer	25. WRITTEN LANGUAGE OF PREFERENCE ☐ I prefer not to answer

* 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 Blue KC 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).
*** Blue Cross and Blue Shield of Kansas City (Blue KC) may use this email address to provide documents, materials and other notices related to coverage.

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

V Coverage Selection: Medical

MEDICARE SUPPLEMENT		MEDICARE SELECT (Selected Hospitals – Unrestricted Physicians)	
☐ Plan A	☐ Plan G ☐ Plan N	☐ Plan B	☐ Plan G ☐ Plan N

Were you Age 65 & 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
If you answered Yes to either question you can select the Products below:

MEDICARE SUPPLEMENT	MEDICARE SELECT (Selected Hospitals – Unrestricted Physicians)
☐ Plan C ☐ Plan F	☐ Plan C ☐ Plan F

[VI Coverage Selection: Dental

Dental PPO Base Plans: *Check if desired.*	**Standard Plan Details:**
☐ **BlueDental** Preventive (Type I) Basic (Type II)	Deductible: $50 for Type II PPO Network Coinsurance: 100% (I) / 80% (II) Premier Network Coinsurance: 100% (I) / 70% (II) Calendar Year Maximum: $1,000

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

VII Other Insurance 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 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.

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

YES	NO	Question
☐ 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?
		D. If yes, what is the effective date? Date: ______________________
☐ YES	☐ NO	E. Are you enrolling in Medicare Part B in the next 6 months?
☐ YES	☐ NO	2. 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?
☐ YES	☐ NO	3. 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	4. A. Do you have another Medicare Advantage plan in force?
☐ YES	☐ NO	B. Have you notified your Medicare Advantage plan of intent to discontinue enrollment? NOTE: It is your responsibility to disenroll from your existing Medicare Advantage plan.
☐ YES	☐ NO	4. A. Have you had coverage under Blue KC or any other health insurance within the past 63 days? (For example, employer, or individual)? 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 under the other policy, leave "END" blank? Start ________________ End ________________
☐ YES	☐ NO	5. If you have dependents on your current BCBSKC individual policy, do you want to continue coverage for the dependents?

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

VIII Eligibility Requirements

Blue KC Medicare Supplement insurance policies are medically underwritten. Your acceptance is guaranteed if you are a Missouri or Kansas resident under age 65 and on Medicare by reason of Disability or End Stage Renal Disease (ESRD), OR are 65 years of age or over and covered by Medicare Part A and have enrolled in Medicare Part B in the last 6 months. Your acceptance may be guaranteed in one or all of the Medicare Supplement plans, based on your guaranteed acceptance rights.

If applicable, please include a copy of the termination notice from your prior insurer with your application.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.

☐ YES	1. I am 65 years or older and I enrolled in Medicare Part B within the last 6 months
☐ YES	2. I will be turning age 65 and will be enrolling in Medicare Part B in the next 6 months
☐ YES	3. I am applying for this policy within 63 days after my group health insurance coverage was terminated.
☐ YES	4. I was enrolled in a Medicare Advantage plan that stopped providing benefits in my area and I am applying within 63 days of either the date on the notification of termination letter or December 31st.
☐ YES	5. I am applying for this policy within 63 days of terminating prior coverage.
☐ YES	6. Are you eligible for Medicare by reason of disability and enrolled in Medicare Part B in the last 6 months?
☐ YES	7. Are you eligible for Medicare by reason of end stage renal disease and enrolled in Medicare Part B in the last 6 months?
☐ YES	8. I am a retiree and my group coverage was terminated.
☐ YES	9. I have active group coverage that will be ending upon my retirement.
☐ YES	10. I de-enrolled from a Medicare Advantage or another Medicare Select Plan within the last 12 months.
☐ YES	11. I de-enrolled from a Medicare Advantage or another Medicare Select Plan when I was first eligible for Medicare Part A within the last 12 months.
☐ YES	12. I was enrolled in a Medicare Advantage plan that either stopped providing benefits in my service area or substantially violated a material provision, or the plan or Agent materially misrepresented the policy, or other reasons specified by Health and Human Services.
☐ YES	13. I was enrolled in a Medicare supplement plan and the insurer either became insolvent, violated a material provision of the policy, or the insurer or Agent misrepresented the policy when it was sold.
☐ YES	14. I moved out of the area where I was enrolled in a Medicare Advantage Plan.
☐ YES	15. None of the above

Member Information (Please provide again to assist in case pages become separated)

LAST NAME: FIRST NAME:

X 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.

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

XI Agreement and Acknowledgement

I understand that if my application is not submitted during an open enrollment or guaranteed issue period, Blue Cross Blue Shield of Kansas City 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 Blue Cross and Blue Shield of Kansas City, 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

If Blue KC receives your application before your 65th birthday, your coverage can begin on the first day of your birthday month.

If your 65th birthday is on the first day of the month, your coverage can begin on the first day of the previous month.

Rates quoted are based upon your age at the time of your initial effective date of coverage and zip code. If requesting a future effective date results in your age changing, your quoted rate may change.

The Benefits and Premium amounts displayed are based on the selected start date and may change if a different date is chosen. If you wish to select a different start date, you will need to click cancel application and start over.

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

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

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. 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?

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)

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

Nondiscrimination Notice

DISCRIMINATION IS AGAINST THE LAW

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

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

If you believe that Blue KC 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.

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

Need This Communication in Another Language?

If you, or someone you're helping, has questions about Blue KC, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-844-395-7126.

1. Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue KC, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-395-7126.

2. Chinese: 如果您，或是您正在協助的對象，有關於 Blue KC 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 1-844-395-7126。

3. Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue KC, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-395-7126.

4. German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Blue KC haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-395-7126 an.

5. Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Blue KC에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-395-7126로 전화하십시오.

6. Laotian: ຖ້າທ່ານ, ຫຼືຄົນທີ່ທ່ານກໍາລັງຊ່ວຍເຫຼືອ, ມີຄໍາຖາມກ່ຽວກັບ Blue KC, ທ່ານມີສິດທີ່ຈະໄດ້ຮັບການຊ່ວຍເຫຼືອແລະຂໍ້ມູນຂ່າວສານທີ່ເປັນພາສາຂອງທ່ານບໍ່ມີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົມກັບນາຍພາສາ, ໃຫ້ໂທຫາ 1-844-395-7126.

7. Arabic: إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Blue KC ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-844-395-7126.

8. Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Blue KC, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-395-7126.

9. French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Blue KC, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-395-7126.

10. Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Blue KC, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-395-7126.

11. Persian: اگر شما، یا کسی که شما به او کمک میکنید ، سوال در مورد Blue KC ، داشته باشید حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت نمایید. 1-844-395-7126 تماس حاصل نمایید .

12. Serbo-Croation: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Blue KC, imate pravo da besplatno dobijete pomo i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-844-395-7126.

13. Pennsylvanian Dutch: "Wann du hoscht en Froog, odder ebber, wu du helfscht, hot en Froog baut Blue KC, hoscht du es Recht fer Hilf un Information in deinre eegne Schprooch griege, un die Hilf koschtet nix. Wann du mit me Interpreter schwetze witt, kannscht du 1-844-395-7126 uffrufe.

14. Cushite: Isin yookan namni biraa isin deeggartan Blue KC irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-395-7126 tiin bilbilaa.

15. Portuguese: Se você, ou alguém a quem você está ajudando, tem perguntas sobre o Blue KC, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para [1-844-395-7126.

Broker Representation (if applicable)

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

PRINTED BROKER'S NAME BROKER SIGNATURE DATE

TELEPHONE NUMBER E-MAIL ADDRESS

Blue KC Broker Number

REQUIRED

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:

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

MEDICARE SELECT DISCLOSURES

If you are applying for Medicare Select, please review this information and sign the back of this form. We must have this form completed to process your application.

- Outline of Coverage – See Enclosed Outline.

- Description of Preferred Network Providers.

The following facilities are open 24 hours a day, seven days a week:

Belton Regional Medical Center, (816) 348-1200, 17065 S. 71 Highway, Belton, MO 64012
Cass Medical Center, (816) 884-3291, 2800 East Rock Haven Road, Harrisonville, MO 64701
Centerpoint Medical Center, (816) 698-7000, 19600 East 39th Street, Independence, MO 64057
Excelsior Springs Medical Center, (816)630-6081, 1700 Rainbow Blvd., Excelsior Springs, MO 64024
Lafayette Regional Health Center, (660) 259-2203, 1500 State Street, Lexington, MO 64067
Lees Summit Medical Center, (816) 282-5000, 2100 SE Blue Pkwy, Lees Summit, MO 64063
Menorah Medical Center, (913) 345-3600, 5721 W. 119th St., Overland Park, KS 66209
North Kansas City Hospital, (816) 691-2000, 2800 Clay Edwards Dr., North Kansas City, MO 64116
Overland Park Regional Medical Center, (913) 541-5000, 10500 Quivira Rd., Overland Park, KS 66215
Research Medical Center, (816) 276-4000, 2316 E. Meyer Blvd., Kansas City, MO 64132
University of Kansas Medical Center, (913) 588-5000, 3091 Rainbow Blvd., Kansas City, KS 66103

- Description of Restricted Network Provisions

You must use a preferred hospital provider for the Medicare Select programs to receive Part A supplemental benefits if the plan you choose includes benefits for such Part A services.

- Description of coverage for emergency and urgently needed care and other out-of-service area coverage.

An emergency is an injury, illness or physical condition that requires immediate diagnosis and treatment for a condition that occurs suddenly and unexpectedly, and that could become a threat to life or limb if medical services are not rendered immediately.

In an emergency, or if urgently needed care is necessary out of the area, you are not required to use a preferred hospital provider. In an emergency situation and when care is urgently needed, full plan benefits are paid when any provider is utilized.

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

• Description of the policyholder's rights to purchase any other Medicare supplement policy or certificate otherwise offered by the insurer.

In the event the Secretary of Health and Human Services does not re-authorize the Medicare Select program, you will be provided continuation of coverage.

1. You will have the opportunity to purchase any Medicare Supplement certificate offered by us which has comparable or lesser benefits and which does not contain a restricted network provision. Evidence of insurability is not required in this instance.

2. A Medicare supplement certificate is considered to have comparable or lesser benefits if the new certificate does not contain one or more significant benefits not included in the Medicare Select Contract being replaced. A significant benefit means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

• Description of the Medicare Select insurer's quality assurance program.

The Quality Improvement program includes on-going assessments of the structure, process and outcome of patient care. These assessments are aimed at problem identification and resolution. The Plan is coordinated by Blue Cross and Blue Shield of Kansas City quality improvement support staff and involves the medical director(s), the Quality Improvement Committee, Blue Cross and Blue Shield of Kansas City staff members, and physician and non-physician providers.

• Description of the Medicare Select insurer's grievance procedure

- Purpose of grievance and complaint procedures. It is our hope that Medicare Select members will move through the health care system with ease. However, we know that some situations may arise which will not meet your expectations. If this occurs, you may wish to verbally express your position or your may wish to formally file a written complaint.

- Procedures for filing a grievance. Grievances and complaints will be handled by the Grievance Coordinator who may involve other staff members or providers of care in making the determination. The objective is to handle the complaint as quickly and as courteously as possible. You may bring a grievance or complaint to our attention by telephone or letter. You may call us at (816) 395-2345 or write to: Blue Cross and Blue Shield of Kansas City, Attn: Medicare Select Grievance Coordinator, P.O. Box 419071, Kansas City, MO 64141-2428.

Acknowledgment: ____ Date: _____________

I hereby acknowledge and certify that I have carefully and completely read the Medicare Select disclosures above and I understand all restrictions and other information described above regarding Blue Cross and Blue Shield of Kansas City's Medicare Select product.

PLEASE RETURN THIS ACKNOWLEDGMENT FORM WITH YOUR COMPLETED APPLICATION. WE MUST HAVE THIS FORM TO PROCESS YOUR APPLICATION IF YOU ARE APPLYING FOR MEDICARE SELECT.

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		