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 Applicant Information

1. LAST NAME FIRST NAME MIDDLE INITIAL	2. DATE OF BIRTH	3. SOCIAL SECURITY NO.

4. *HOME ADDRESS (Street Number and Name, Apt. Number)			
5. CITY	6. STATE	7. ZIP	8. COUNTY

9. ALTERNATE ADDRESS* (Please indicate only one): ☐ Billing Only ☐ Billing and All Correspondence

10. CITY	11. STATE	12. ZIP	13. COUNTY

14. DAYTIME PHONE	15. HOME PHONE	16. 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.

** 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.

II 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 also select from the Products below:

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

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.

NAME OF BENEFICIARY _____

MEDICARE NUMBER _____ SEX _____

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: SOCIAL SECURITY NO.:

III Coverage Selection: Dental

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

IV Other Information Required for Issuance and Continuous Coverage

☐ YES	☐ NO	1. A. Did you turn age 65 in the last 6 months?
☐ YES	☐ NO	B. Did you enroll in Medicare Part B in the last 6 months? C. 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 "Spend-down Program" and have not met your "Share of the 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?
☐ 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 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	6. 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: SOCIAL SECURITY NO.:

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.

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.

VI Medical Questionnaire

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 acceptance? ☐ YES ☐ NO

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

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

VII Medical Questionnaire - Complete only if NOT applying during a GI or OE period.

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:	SOCIAL SECURITY NO.:

VIII 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**

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	

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: SOCIAL SECURITY NO.:

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 1-844-395-7126 로 전화하십시오.

6. Laotian: ຖ້າ ທ່ານ, ຫ ຼື ຄົນ ທ່ ານ ກໍ ລັ ງ ຊ່ ວ ຍ ເຫ ຼື ອ, ມ ຄ ໍ າ ຖ າ ມ ກ ່ ຽ ວ ກ ັ ບ Blue KC, ທ ່ ານ ມ ີ ສ ິ ດ ທ ີ ່ ຈ ະ ໄ ດ ້ ຮ ັ ບ ການ ຊ ່ ວ ຍ ເ ຫ ຼ ື ອ ແ ລ ະ ຂ ໍ ້ ມ ູ ນ ຂ ່ າ ວ ສ ານ ທ ີ ່ ເ ປ ັ ນ ພ າ ສ າ ຂ ອ ງ ທ ່ ານ ບ ໍ ່ ມ ີ ຄ ່ າ ໃ ຊ ้ จ ่ าย. ການ ໂ ອ ้ ລ ົ ມ ກ ັ ບ ນ າ ຍ ພ າ ສ າ, ໃ ຫ ้ ໂ ທ ຫ າ 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 pomoći 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.

Blue KC 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:

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

LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

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 the sudden and, at the time, unexpected onset of a health condition that manifests itself by symptoms of sufficient severity that would lead a prudent layperson, possessing an average knowledge of health and medicine, to believe that immediate medical care is required. Such a condition may include, but shall not be limited to:

a. Placing the person's health in significant jeopardy;
b. Serious impairment to a bodily function;
c. Serious dysfunction of any bodily organ or part;
d. Inadequately controlled pain; or
e. With respect to a pregnant woman who is having contractions:
   (1) That there is inadequate time to effect a safe transfer to another Hospital before delivery; or
   (2) That transfer to another Hospital may pose a threat to the health or safety of the woman or unborn child.

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.

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LAST NAME: FIRST NAME: SOCIAL SECURITY NO.:

• 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.