Alaska Medicare Supplement Enrollment Application for Plans A, G, High Deductible G and N

PO Box 327, MS 295
Seattle, WA 98111
888-669-2583
Fax: 425-918-5278

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

You are eligible to apply for a Premera Blue Cross Blue Shield of Alaska (Premera) Medicare Supplement plan if you:

- Reside in Alaska,
- Currently have both Medicare Part A and Part B, and
- Don't receive Medicaid assistance other than payment of your Medicare Part B premium.

Please type your answers or print clearly in ink so we can process your application quickly. Be sure to return all pages to us. Omissions, incomplete answers, or the use of correction fluid or tape will result in the return of your application and may cause a delay in the effective date of your coverage.

A Medicare Information

If you have 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 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:**

Please mark Y (Yes) or N (No) with an "X."

To the best of your knowledge:

☐ Y ☐ N **1.** Did you turn age 65 in the last 6 months?

☐ Y ☐ N **2.** Did you enroll in Medicare Part B in the last 6 months?

3. If Yes, what is the effective date?
_____ / _____ / _____

Medicare Number:
☐☐☐☐☐☐☐☐☐☐☐

Hospital (Part A) Effective Date:
☐☐/01/☐☐☐☐

Medical (Part B) Effective Date:
☐☐/01/☐☐☐☐

Please fill in your Medicare Number and effective dates in the box above using the information from your Medicare card or attach a copy of your Medicare Card. We need all characters to enroll you.

B Personal Information

Last Name	First Name		Middle Initial	
Home Address (cannot be a P.O. Box or business address)	City	County	State **AK**	Zip
Mailing Address (If different from above)	City		State	Zip
Billing Address (If different from both above)	City		State	Zip
Phone Number	Alternate Phone Number			
Email Address*	Birthdate (Month/Day/Year) _____/_____/_____	Gender ☐ Male ☐ Female		

****Important Note:** *We can send enrollment notifications, information about how to use your plan, your Welcome Kit and a copy of this application to you by email instead of a paper copy.*
Do you want to receive enrollment notifications, information about how to use your plan, your welcome kit and a copy of this application by email? ☐ Yes ☐ No

B Personal Information continued

Race (Optional)

Premera is committed to serving the diverse needs of all of our members. These fields are completely optional. If you'd like to self-identify, please do so. To change these selections at any time please call 1-855-339-5205. The collection of this information will not determine eligibility, rating or claim payments.

(Check One)

- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Two or More Races
- ☐ Other Race

Ethnicity (Optional)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Language (Optional)

Please select the language in which you're proficient. If you're proficient in the English language as well as others, please select English from the list. To change these selections at any time please call 1-855-339-5205. The collection of this information will not determine eligibility, rating or claim payments.

- ☐ English
- ☐ Spanish
- ☐ Chinese
- ☐ Vietnamese
- ☐ Korean
- ☐ Russian
- ☐ Tagalog
- ☐ Arabic
- ☐ Italian
- ☐ French/Haitian Creole French
- ☐ Portuguese
- ☐ German
- ☐ Polish
- ☐ Greek
- ☐ Japanese
- ☐ Other _____

C Plan selection

Which Medicare Supplement plan do you want to enroll in?

☐ Plan A ☐ Plan G ☐ Plan G High Deductible ☐ Plan N ☐ Plan F* ☐ Plan F High Deductible*

***Note:** Only those applicants who were initially eligible for Medicare before January 1, 2020, may also apply for plans F and High Deductible F.

Plan start date

You are eligible for coverage to start on the first of the month after the application postmark date if all information is completed and accurate **and** we approve your application. Please indicate the month you want your coverage to start.

I want this plan to begin on the first of _____. (No more than 90 days after the application is signed.)
(enter month)

D Paying for your Medicare Supplement plan

DO NOT send payment with this application.

You will get monthly paper bills if you do not select automatic monthly withdrawals.

A government agency or any other third party may not sponsor or pay for your individual health plan, except as required by law.

Tip – Save $60/yr

Sign up for automatic monthly withdrawals and save $60 a year. Call us at 888-669-2583 for more information.

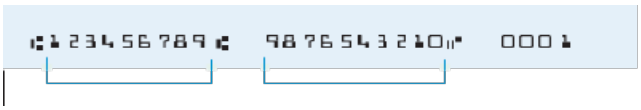
D Paying for your Medicare Supplement plan continued

Please complete below if you are selecting automatic monthly withdrawal

I have selected automatic monthly withdrawal and I hereby authorize Premera to initiate funds transfer from the bank or financial institution account indicated below. I authorize my financial institution to honor these transfers.

Account holder's name (print)			
Financial institution or bank name	City	State	Zip
Bank routing number (see picture below)	Account number (see picture below)	☐ Checking ☐ Savings	

Fill out the information above –or– send us a photocopy of your voided check.



Bank Routing Number Account Number

Additional terms and conditions:

- Funds are transferred on the fifth business day of each month to pay for that month's coverage. (For example, the deduction on February fifth pays for coverage in February.)
- I understand that my monthly subscription charges will be automatically withdrawn from my bank account each month until I notify Premera that it should be cancelled. To ensure cancellation, I must notify Premera no later than the twentieth of the month to be effective for the following month's automatic withdrawal. I have the right to stop payment on a specific bank transfer at least 3 days prior to the next scheduled withdrawal date.
- It may take as long as 45 days to set up the funds transfer. I may receive a paper bill to cover the initial month(s) while the transfer is being set up.

Bank account holder signature **X**	**Today's date**

E Other healthcare information

Please review the statements below, then answer all questions to the best of your knowledge

- You do not need more than one Medicare Supplement insurance policy
- You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- 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 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 while you are covered under the employer or union-based group health plan upon your request. If your Medicare Supplement policy is suspended under these circumstances, and you later lose your employer or union-based group health plan, your suspended Medicare Supplement policy or, if that policy is no longer available, a substantially equivalent Medicare Supplement policy will be reinstituted if requested within 90 days of losing your employer or union-based health plan. If your 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 include outpatient prescription drug coverage.
- 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).

Tell us about any help you receive from your state's Medicaid program (required):

☐ Y ☐ N **1.** a. Are you covered for any 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 Cost," please answer **No** to this question.

☐ Y ☐ N b. If **Yes**, will Medicaid pay your premiums for this Medicare Supplement plan?

☐ Y ☐ N c. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B Premium?

Tell us about your Medicare Supplement coverage (required):

☐ Y ☐ N **2.** a. Do you have another Medicare Supplement policy in force?

☐ Y ☐ N b. If so, with what company, and what plan do you have? Company(Carrier):_____
Plan (Plan ID):_____ Termination Date: _____ / _____ / _____

☐ Y ☐ N c. If so, do you intend to replace your current Medicare Supplement policy with this plan?

Tell us about your Medicare Advantage coverage (required):

☐ Y ☐ N **3.** a. Have you had coverage from any Medicare plan other than original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO)? If so, fill in your start and end dates below. **If you are still covered under this plan**, leave "End" blank.
Start: ____ / ____ / _____ End: _____ / _____ / _____ Company(Carrier):_____

☐ Y ☐ N b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement plan?

☐ Y ☐ N c. Was this your first time in this type of Medicare plan?

☐ Y ☐ N d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan?

E Other healthcare information continued

Tell us about any other health insurance coverage:

☐ Y ☐ N **4.** a. Have you had coverage under 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 (Carrier): _____ Policy (Policy #): _____

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: _____ / _____ / _____

☐ Y ☐ N d. Did this policy cover skilled nursing facility care?
If you are unsure, do not answer.

e. What was the out-of-pocket maximum for this policy? $_____
If you are unsure, leave blank.

F Your health conditions

Answer these health questions to determine if you are eligible for this coverage.

Did you enroll in Medicare Part B in the last six months? If YES, SKIP to Section G. If NO, fill out this section.

1. Do any of these conditions apply to you? ☐ Y ☐ N

- End stage renal (kidney) disease
- Currently receiving dialysis
- Diagnosed with kidney disease that may require dialysis
- Cirrhosis/liver failure
- Chronic obstructive pulmonary disorder (COPD)
- Have a bleeding (coagulation leukemia defect), blood disorder or leukemia
- Insulin dependent diabetes
- Rheumatoid arthritis, joint replacement
- Schizophrenia, bipolar mood, attempted suicide or eating disorder
- Transplant (excludes corneal)

2. Within the past 5 years, has a medical professional diagnosed, discussed, or recommended treatment options for any of the following conditions? ☐ Y ☐ N

- Alcohol, or chemical/drug abuse or dependence
- DVT (clots) or PVD (peripheral vascular disease)
- Ulcerative colitis or Crohn's disease
- Heart attack, congestive heart failure, coronary artery disease, pacemaker, stenosis, or heart valve prolapse or transplant
- Stroke/TIA or paralysis
- Prostatitis
- Chronic bronchitis or tuberculosis
- Chronic back/neck/disc problems

STOP

If you answered YES under questions 1 or 2 in this section, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time.

For information regarding plans that may be available, contact your local state department on aging.

If you answered NO to both questions 1 and 2, your answer to questions 3 and 4 will be used to determine if your application will be accepted.

3. Height and weight:

Height Feet Inches	Weight / lbs.

4. Have you taken medications within the past year?

☐ **Yes.** Please enter your medication information in the table provided below.

☐ **No.** Please move on to Section G.

Medication Name	How long have you been taking this medication?	What does this medication treat?

G Authorization and verification of information

I, the undersigned, apply for enrollment with Premera Blue Cross Blue Shield of Alaska (Premera). I represent that all statements and answers on this application are complete and true. I understand coverage is available to me due to: (1) my residing in Alaska, (2) my enrollment in Medicare Parts A and B, (3) my eligibility for Medicare due to age (65 or over), and (4) I don't receive Medicaid assistance other than payment of my Medicare Part B premium. I understand and agree that coverage does not begin until Premera accepts this application and assigns an effective date of coverage and that receipt of my money (cash, check or money order) does not constitute enrollment under any Medicare Supplement program. I authorize Premera, at its option, to pay providers directly for services rendered. I also understand and agree that Premera may:

1. Accept this application; or
2. Deny this application, in which case any subscription charges submitted will be refunded to, and accepted by me; or
3. Within the first two years of my coverage, void my contract (in other words, cancel my coverage back to its effective date, as if never existed at all) if I have made any intentionally false or misleading statements on this application or enrollment form that are material enough to affect my acceptability for coverage.

I understand that Premera may collect, use, and disclose personal information about me as required or permitted by law or to perform routine business functions, such as determining my eligibility for enrollment, credit for waiting periods, and benefits; paying claims; and fulfilling other obligations stated in its contract with me. If Premera discloses my personal information for any other reason, Premera will first remove any data that can be used to easily identify me or will get my signed authorization.

I further understand that any physician, health care provider, hospital, insurance or reinsurance company, pharmacy benefits manager or third party benefits administrator may disclose my personal health information, including any and all diagnostic, procedural, treatment, claim, prescription or other health related information including records concerning alcohol and/or chemical dependency, reproductive health (including abortion), sexually transmitted diseases, HIV, AIDS, psychiatric disorders and mental illness to Premera or its representatives as allowed by law.

I understand that it is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

I understand that the Medicare Supplement contract will not pay benefits during the first three months after the effective date for any condition for which I have had treatment, medicine or diagnostic testing within the three months prior to my effective date. I understand that, under certain conditions, this limitation may be shortened or waived. **The waiting period may be waived if I apply for this contract within 63 days of leaving other healthcare coverage and I provide proof with this application.**

I understand I am responsible for canceling any prior coverage.

If you answered yes to questions 3 or 4 in Section E, you must complete and sign the attached replacement notice.

☐ I acknowledge receipt of the ***Guide to Health Insurance for People with Medicare*** and the Outline of Coverage.

I have read all information and have answered all questions to the best of my ability.

Signature of applicant	Today's date
X	

Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.

! ! ! IMPORTANT: Be sure to return the entire application. ! ! !

Continue to the next page for the Replacement Notice

For producer use only

Be sure to return this page to us even if you do not have a producer.

If this application is being submitted through a producer, he or she must complete the information below and the attached Notice of Replacement, if appropriate. If all questions are not answered completely, this application will be returned.

Completion of this section by a producer is required.

1. List any other medical or health insurance policies sold to the applicant. _____
   _____
2. List policies sold which are still in force. _____
   _____
3. List policies sold in the past five years which are no longer in force. _____
   _____

Producer Name (Please print)	Premera producer number	Telephone number	
Preferred contact address	City	State	Zip
Producer email address			
Producer signature **X**		Date	

PREMERA | BLUE CROSS BLUE SHIELD OF ALASKA

Discrimination is Against the Law

Premera Blue Cross Blue Shield of Alaska (Premera) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Premera provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). Premera provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, contact the Civil Rights Coordinator. If you believe that Premera has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with: Civil Rights Coordinator ─ Complaints and Appeals, PO Box 91102, Seattle, WA 98111, Toll free: 855-332-4535, Fax: 425-918-5592, TTY: 711, Email AppealsDepartmentInquiries@Premera.com. 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 Ave 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.

Language Assistance

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-508-4722 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-508-4722 (TTY: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-508-4722 (TTY: 711) 번으로 전화해 주십시오.

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-508-4722 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-508-4722 (телетайп: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-508-4722 (TTY：711）。

MO LOU SILAFIA: Afai e te tautala Gagana fa'a Sāmoa, o loo iai auaunaga fesoasoan, e fai fua e leai se totogi, mo oe, Telefoni mai: 800-508-4722 (TTY: 711).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 800-508-4722 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-508-4722 （TTY:711）まで、お電話にてご連絡ください。

PAKDAAR: Nu saritaem ti Ilocano, ti serbisyo para ti baddang ti lengguahe nga awanan bayadna, ket sidadaan para kenyam. Awagan ti 800-508-4722 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-508-4722 (TTY: 711).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки.
Телефонуйте за номером 800-508-4722 (телетайп: 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-508-4722 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-508-4722 (TTY: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-508-4722 (TTY: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-508-4722 (رقم هاتف الصم والبكم: 711).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 800-508-4722 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-508-4722 (ATS : 711).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 800-508-4722 (TTY: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-508-4722 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 800-508-4722 (TTY: 711) تماس بگیرید.