APPLICATION BOOKLET

for BlueChoice 65

A Medicare Supplement Program including BlueChoice 65 SELECT

BlueCross BlueShield of Louisiana

An independent licensee of the Blue Cross and Blue Shield Association.

23XX2461 R01/10

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

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APPLICATION FOR BLUE*CHOICE 65*/BLUE*CHOICE 65 SELECT* HEALTH COVERAGE

01 ______ 02 ______ 03 ______ 04 ______

OFFICE USE ONLY	CONTRACT NUMBER	CONTRACT DATE	GROUP #	MOP	TOTAL FEES	CLK.	MED. INFO ON FILE	U.W. INT. & DATE
			REQUESTED EFF. DATE		AGENT #		PARISH	AREA CD.

PLEASE CHECK: ☐ BC 65 DISABILITY ☐ BC 65 ☐ BC 65 SELECT DISABILITY ☐ BC 65 SELECT

SOCIAL SECURITY NO.	LAST NAME (Print)	FIRST (Print)	MIDDLE (Print)	AC ( ) PHONE NO.
STREET ADDRESS	CITY	STATE	ZIP CODE	DO YOU WANT COMBINED BILLING? ☐ YES ☐ NO
DATE OF BIRTH MONTH DAY YEAR	☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ MARRIED	ARE YOU ENTITLED TO MEDICAID? ☐ YES ☐ NO QMB ASSISTANCE? ☐ YES ☐ NO SLMB ASSISTANCE? ☐ YES ☐ NO	
EFFECTIVE DATE OF MEDICARE PART A. MO DAY YR	EFFECTIVE DATE OF MEDICARE PART B. MO DAY YR	YOUR MEDICARE NUMBER	ARE YOU CURRENTLY RECEIVING DISABILITY/WORKERS' COMP. BENEFITS? ☐ YES ☐ NO	

METHOD OF PAYMENT: PREMIUM $______ ☐ MONTHLY ☐ SEMI-ANNUALLY ☐ QUARTERLY ☐ ANNUALLY ☐ BANK DRAFT

BENEFIT DESIGN: CHECK ONE OF THE FOLLOWING PLANS

BLUE*CHOICE 65* PLANS: ☐PLAN A ☐PLAN B ☐PLAN F ☐PLAN N **BLUE*CHOICE 65 SELECT* PLANS:** ☐PLAN B ☐PLAN F ☐PLAN N

HEALTH HISTORY **IF YES TO QUESTIONS BELOW, EXPLAIN ON REVERSE SIDE, INCLUDING MEDICATIONS AND DOSAGES.**

1. Have you been advised by a physician to receive inpatient hospital treatment or undergo a surgical operation that has not been performed? ☐ YES ☐ NO
2. Are you currently a patient in a hospital, nursing home, or medical care facility? Have you been a patient in any of these facilities two or more times in the past two years? ☐ YES ☐ NO
3. Within the past two years, have you had or received treatment for internal cancer, malignant melanoma, heart condition (ex. heart attack, congestive heart failure) or circulatory system (ex. hardening of the arteries), or stroke? (Excludes high blood pressure.) ☐ YES ☐ NO
4. Have you been treated in the past two years for diabetes requiring insulin, emphysema or other obstructive lung disease, kidney disease requiring dialysis? ☐ YES ☐ NO
5. Do you take prescription drugs on a regular (daily or weekly) basis? If yes, please list drug name(s) and reason why taken. If needed, use Medical Questionnaire on back. If none taken, indicate None.
   DRUGS: ______ REASON: ______

Total monthly cost of prescription drugs: $______

1. I, the undersigned, do hereby apply for membership in Louisiana Health Service & Indemnity Company (LHSIC), for myself. I understand that this application, any Change of Status Card and the Contract, together with any riders and endorsements issued by LHSIC constitute my contract with LHSIC. I understand the contract may be terminated within three years of the original effective date of the Member's coverage and all fees, less claims paid, will be refunded if a material misrepresentation of facts as to that Member(s) exists in the application or any Change of Status Card.
2. I understand that the coverage applied for is not part of a group health plan and that the agreement is between LHSIC and myself.
3. PROXY - I hereby constitute and appoint the directors of LHSIC, present in person or by proxy given to another director(s), to vote on my behalf at membership meetings on any matters on which policyholders are entitled to vote. **I acknowledge notice that the annual meeting of the policyholders is held on the third Tuesday in February or on the next business day following, if a legal holiday.** Notice of any such meeting given to such director(s) constitutes notice to me. Payment of each premium extends the proxy's effectiveness unless revoked by the policyholder as hereafter provided. I understand that if I revoke my proxy, I may continue to pay my premium without affecting the revocation or my coverage. I understand that I may designate any other policyholder as my proxy by sending any form of writing to Louisiana Health Service & Indemnity Company at P. O. Box 98029, Baton Rouge, Louisiana 70898. **Check this block if you do not want to grant your proxy.** ☐
4. I understand that this is an application for coverage and is not binding on LHSIC. I understand that LHSIC reserves the right to set the effective date for any Contract issued and that the Contract will not become effective until that date is established by LHSIC.
5. I acknowledge that I have received both an outline of Medicare Supplement coverage and a "Guide to Health Insurance for People with Medicare."
6. If choosing Blue*Choice 65 SELECT*, I acknowledge that I have received a listing of network hospitals participating in the Blue*Choice 65 SELECT* program and disclosure information on the Blue*Choice 65 SELECT* program.
7. I understand that Blue*Choice 65 SELECT* plan benefits will not be provided for the Part A Medicare deductibles and coinsurance when hospitalized in a non-network hospital, except in the case of emergencies.

Blue Cross and Blue Shield of Louisiana incorporated as Louisiana Health Service & Indemnity Company

IMPORTANT! Please answer all questions below for all persons included in this application. For each positive response, underline the appropriate statement or condition and complete the medical questionnaire on page 3. Any personal health information (PHI) obtained by Blue Cross and Blue Shield of Louisiana in connection with this application may be retained by Blue Cross and Blue Shield of Louisiana and used or disclosed in connection with future underwriting or renewal efforts.

Your Height:__________ Your Weight:__________ Spouse's Height:__________ Spouse's Weight:__________

HAS ANYONE APPLYING FOR COVERAGE EVER HAD OR BEEN DIAGNOSED WITH:

1. Diabetes Mellitus? ☐ Yes ☐ No
2. Any type of Cancer? ☐ Yes ☐ No
3. Any blood disorder? ☐ Yes ☐ No
4. A stroke (CVA)? ☐ Yes ☐ No
5. Circulatory problems? ☐ Yes ☐ No
6. Epilepsy? ☐ Yes ☐ No
7. Rheumatic Fever? ☐ Yes ☐ No
8. Abnormal blood pressure? ☐ Yes ☐ No
9. Heart Trouble? ☐ Yes ☐ No
10. Diagnosed with Tuberculosis? ☐ Yes ☐ No
11. Had or have other lung problems? ☐ Yes ☐ No
12. Tested positively for HIV, had known exposure to AIDS or HIV, or received treatment for AIDS or ARC? ☐ Yes ☐ No
13. Either Hepatitis or a liver disorder? ☐ Yes ☐ No

IN THE LAST 5 YEARS HAS ANYONE APPLYING FOR COVERAGE:

14. Been diagnosed with asthma, bronchitis or chronic sinus trouble? ☐ Yes ☐ No
15. Been diagnosed with allergies? ☐ Yes ☐ No
16. Been treated for arthritis? ☐ Yes ☐ No
17. Been treated for Rheumatism/Bursitis or Sciatica? ☐ Yes ☐ No
18. Had any bodily deformities? ☐ Yes ☐ No
19. Had any back/orthopedic condition or muscular diseases? ☐ Yes ☐ No
20. Had any known tumors or cysts? ☐ Yes ☐ No
21. Been treated for kidney stones or urinary system disorders, diabetes insipidus or prostate disorders? ☐ Yes ☐ No
22. Been diagnosed with an endocrine disorder, thyroid problem or goiter? ☐ Yes ☐ No
23. Been treated for hemorrhoids/rectal ailments or varicose veins? ☐ Yes ☐ No
24. Had a hernia? ☐ Yes ☐ No
25. Had seizures, fainting spells? ☐ Yes ☐ No
26. Had headaches? ☐ Yes ☐ No
27. Had irregular/excessive menstrual bleeding? ☐ Yes ☐ No
28. Had any other female reproductive problems? ☐ Yes ☐ No
29. Had pelvic pain? ☐ Yes ☐ No
30. Had gall stones or gall bladder disorder? ☐ Yes ☐ No
31. Had abdominal pain? ☐ Yes ☐ No
32. Had ulcers, stomach, colon or other intestinal disorders, adhesions? ☐ Yes ☐ No
33. Had any eye conditions (excluding corrective lenses)? ☐ Yes ☐ No
34. Had any ear condition or impairment? ☐ Yes ☐ No
35. Had a mental/nervous disorder (including eating disorders) or any psychiatric/psychological consultation? ☐ Yes ☐ No
36. Had candidiasis (yeast infection), herpes, syphilis, gonorrhea, condylomata acuminata (genital warts), or other sexually transmitted diseases? ☐ Yes ☐ No
37. Suffered from or received treatment for alcohol or substance abuse, detoxification? ☐ Yes ☐ No
38. Had any condition (including developmental defects or deformities) of oral cavity, jaw, facial or cranial bones, teeth and surrounding structures? ☐ Yes ☐ No

MISCELLANEOUS

39. Are you expecting a biological child within the next 9 months (male or female applicant)? ☐ Yes ☐ No
40. Have you, or anyone on this application, used tobacco in any form within the last 12 months? ☐ Yes ☐ No
41. Are you presently taking medications for conditions not mentioned in other questions? (please list medications). ☐ Yes ☐ No
42. Are you, or anyone on this application, engaged in private flying, parachuting, hang gliding, racing, underwater diving, handling of explosive materials, hazardous wastes or materials? ☐ Yes ☐ No
43. Have you, or anyone on this application, ever had any health insurance postponed, rated, ridered, declined, canceled, or had reinstatement refused? ☐ Yes ☐ No
44. Any departure from good health or any medical or surgical advice or treatment from any medical practitioner (medical doctor/surgeon, podiatrist, optometrist, chiropractor, dentists/oral surgeons, etc.) in the last 5 years? ☐ Yes ☐ No

PROVIDE DETAILS ACCORDING TO THE MEDICAL QUESTIONNAIRE GUIDE

Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.
Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.
Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.
Question Number: ______ Person: ______ Condition: ______ Comments:	a. b. c. d. e. f. g.

FRAUD STATEMENT

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

THIS APPLICATION HAS BEEN COMPLETED IN MY PRESENCE

Producer's Signature ______ Date ______

Patricia Freeman

Print Name ______ Date ______

trish@insurancelady.com

Producer's E-Mail Address

Met with applicant in person: ☐ Yes ☐ No

Physical Requested: ☐ Yes ☐ No

I acknowledge receipt of the documents stated in this application. All of the questions in the health history section have been read by or to me and the answers given are provided by the applicant.

Applicant's Signature ______ Date ______

Print Name (Applicant) ______ E-Mail Address ______

Relationship to Applicant ______

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BlueChoice 65

A Medicare Supplement Program

BlueChoice 65 SELECT

Supplementary Application for Medicare Supplement Coverage

Instructions:

- Carefully read the Statements in Section 1.
- Answer the questions in Section 2 to the best of your knowledge.
- Sign the form.
- Agent must complete Section 3 and sign.

SECTION 1 Statements

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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.
5. 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 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 the suspension.
6. 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).

SECTION 2 Questions (To Be Answered By Applicant)

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.

PLEASE ANSWER ALL QUESTIONS. [Please mark Yes or No below with an "X"]

To the best of your knowledge,

1.(a) Did you turn 65 in the last 6 months? ☐ Yes ☐ No

(b) Did you enroll in Medicare Part B in the last 6 months ☐ Yes ☐ No

(c) If yes, what is the effective date? ____________________

2. Are you covered for medical assistance through the state Medicaid program?

[NOTE TO APPLICANT: If you are a participant in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.]

☐ Yes ☐ No

If yes,

(a) Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

(b) 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. If you are still covered under this plan, leave "END" blank.

START __/__/__ END __/__/__

(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? ☐ Yes ☐ No

(b) If so, with what company, and what plan do you have? ________________________

(c) If so, do you intend to replace your current Medicare supplement policy with this policy ☐ Yes ☐ No

5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) ☐ Yes ☐ No

(a) If so, with what company and what kind of policy? ________________________

____

(b) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.) START __/__/__ END __/__/__

SECTION 3 Agent Must Complete This Section

Agents shall list any other health insurance policies they have sold to the applicant.

1. List policies sold which are still in force.

____

2. List policies sold in the past five (5) years which are no longer in force.

____

____
Applicant's Name (Print)

________________________ __________
Agent/Broker's Signature Date

X_______________________ __________
Applicant's Signature Date

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Blue Cross and Blue Shield of Louisiana* • P. O. Box 98029 • Baton Rouge, LA 70898-9029

Instructions:

- **This form (and copy on opposite page) should be completed only if you plan to replace your existing Medicare supplement policy. Your agent will fill in the information required.**
- **After your agent completes the form, sign it at the bottom.**
- **Detach copy for your records.**

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Blue Cross and Blue Shield of Louisiana. 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 AGENT, BROKER OR AUTHORIZED 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) ______________________________
____

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 you want to keep it.

____
Signature of Agent, Broker, or other Representative

Blue Cross and Blue Shield of Louisiana
P. O. Box 98029
Baton Rouge, LA 70898-9029

____
Date

____
Applicant's Name (Print)

X ______________________________
Applicant's Signature

____
Date

COMPANY COPY

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