

Supplement-65 Application (District of Columbia Residents)

(Coverage designed to supplement benefits under Medicare)

For assistance in completing this application,
call 1-877-634-1256



Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS ▼

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign this application on page 7 and return it in the postage-paid envelope, if provided. Or mail to:

APPLICATION PROCESSING
5965 SANDY RIDGE
ELKRIDGE, MARYLAND 21075

3. You will be notified by mail if this application is accepted.

Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If incomplete, the application will be returned and delay your coverage.

OFFICE USE ONLY:

ID #:	EFF DATE:
GROUP #:	CLASS:

▼ PLEASE CORRECT ANY INCORRECT NAME OR ADDRESS INFORMATION BELOW ▼

Last Name			First Name			Middle Initial		
Residence Address (Number and Street)								
City			State			Zip Code		

1. APPLICANT INFORMATION ▼

Billing Address, if different from Residence Address: (Number & Street) (City & State) (Zip Code-9 digit, if known)

Date of Birth: / /	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married
Home Phone: () ()	Work Phone: () ()	Did you establish permanent residence at the above address within the last 31 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
Type of Coverage Selected: (check one) <input type="checkbox"/> Plan A <input type="checkbox"/> Plan C <input type="checkbox"/> Plan F	E-mail Address: _____	
NOTE: If you are under age 65 and have Medicare, you may apply for Plan A or Plan C Only.	Your Social Security (or Railroad Retirement) Number: _____	

2. MEDICARE COVERAGE INFORMATION ▼

Please provide the following Medicare Information as printed on your red, white and blue Medicare identification card.
You must have both Medicare Part A (hospital) and Medicare Part B (medical/surgical) coverage or will obtain Medicare coverage before the effective date of this Supplement-65 policy.

Reason for Entitlement: Age 65 or over Kidney Disease Disabled

HEALTH INSURANCE CLAIM NUMBER:	MEDICARE HOSPITAL (PART A) EFFECTIVE DATE: MONTH DAY YEAR	MEDICARE MEDICAL/SURGICAL (PART B) EFFECTIVE DATE: MONTH DAY YEAR
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FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:			
Sub-Agent/Sub-Agency:			
Writing Agent:			

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

3. ELIGIBILITY 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. PLEASE ANSWER ALL QUESTIONS.

To the best of your knowledge,

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? Yes No
(c) If yes, what is the effective date? _____

2. Are you covered for medical assistance through the State Medicaid program? Yes No
(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.)
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 yes, with what company, and what plan do you have? _____
(c) If yes, 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? Yes No
(For example, an employer, union, or individual plan)
(a) If yes, with what company and what kind of policy?

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

ADDITIONAL CONSUMER INFORMATION ▼

- 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 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 reinstated 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 reinstated 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the 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).

4. PRIOR COVERAGE INFORMATION ▼

WITHIN THE PAST 63 DAY PERIOD WERE YOU ENROLLED UNDER:

1. An employee welfare benefit plan that supplemented Medicare benefits and the plan terminated or ceased to provide you with all of the supplemental health benefits? Yes No
2. A Medicare Advantage* plan, or a Program of All-Inclusive Care for the Elderly (PACE) provided under Section 1894 of the Social Security Act, and:
 - (a) the plan's certification under the federal Social Security Act terminated, or the organization no longer provides the plan within the service area in which you reside? Yes No
 - (b) you were unable to continue coverage with the plan because you moved out of the plan's service area? Yes No
 - (c) you can demonstrate that the issuer of the policy substantially violated a material provision of the plan, including a failure to provide medically necessary care on a timely basis or in accordance with medical standards? Yes No
 - (d) you can demonstrate that the issuer or an agent of the issuer materially misrepresented the plan provisions in marketing the policy? Yes No
 - (e) the issuer has notified you that your plan is being discontinued in the area in which you reside? Yes No
3. A Medicare Supplemental policy and your enrollment ceased because:
 - (a) of any involuntary termination of coverage or enrollment under the policy, including termination caused by the bankruptcy of an organization providing the plan? Yes No
 - (b) the issuer of the policy substantially violated a material provision of the policy? Yes No
 - (c) the issuer (or agent or entity acting on the issuer's behalf) materially misrepresented the policy's provision in marketing the policy? Yes No
4. A Medicare Supplemental policy, and transferred your enrollment, **for the first** time to any Medicare Advantage* plan or a PACE plan? SEE THE NOTE BELOW BEFORE ANSWERING THIS QUESTION. Yes No
5. A Medicare Advantage* plan or a PACE plan that you enrolled in upon first becoming eligible for benefits under Medicare Part B at age 65? SEE THE NOTE BELOW BEFORE ANSWERING THIS QUESTION. Yes No

NOTE: You must meet all three requirements below, a, b, and c, in order to answer YES to question 4 or 5.

If any of these items, a, b, or c, are not true, then you must check NO in the box.

- (a) This was the "**first time**" you selected a Medicare Advantage* plan or a PACE plan. If you transferred between different Medicare Advantage* plans or PACE plans, without going back to fee-for-service Medicare, then it will still be considered your "**first time**".
- (b) During this "**first time**", you were not covered under any one Medicare Advantage* plan or a PACE plan for a period of more than 12 months.
- (c) It has not been more than 2 years since you first transferred out of the fee-for-service Medicare program. Yes No

*Medicare Advantage plan includes: Coordinated care plans that provide health care services, including health maintenance organization plans (with or without a point-of-service option), plans offered by provider-sponsored organizations, and preferred provider organization plans; medical savings account plans coupled with a contribution into a Medicare Advantage Plan medical savings account; and Medicare Advantage private fee-for-service plans..

If you answered YES to any of the questions above. 1) You will NOT have to meet the pre-existing condition waiting period. 2) You must submit evidence of the date of termination or disenrollment of the other plan along with this application. 3) You do NOT have to complete sections 5 or 6 and can skip to section 7.

5. CREDITABLE COVERAGE INFORMATION ▼

1. At the time of this application, are you within 6 months from the first day of the month in which you first enrolled or will enroll in Medicare Part B? Yes No

If you answered YES, please go to the next question. If you answered NO, please skip ahead to Section 6.

2. Are you age 65 or older or will you be age 65 before the effective date of this Supplement-65 policy? Yes No

If you answered YES, please go to the next question. If you answered NO, please skip ahead to Section 6.

3. At the time of this application, do you have a continuous period of Creditable Coverage of at least 6 months, without a break in this coverage of more than 63 consecutive days? Yes No

If you answered NO, please go to the next question. If you answered YES, you will NOT have to meet the pre-existing condition waiting period. You must submit evidence of the Creditable Coverage along with this application. Please skip ahead to Section 6.

4. At the time of this application, do you have a continuous period of Creditable Coverage of less than 6 months, without a break in this coverage of more than 63 consecutive days? Yes No

If you answered YES, then the 90 day pre-existing condition waiting period will be reduced by the number of months of your Creditable Coverage. You must submit evidence of the Creditable Coverage along with this application.

Documents that may be used as evidence of “creditable coverage” in the absence of a certificate include explanations of benefit claims (EOB) or other correspondence from a plan or issuer indicating coverage, paystubs showing a payroll deduction for health coverage, a health insurance identification card, a certificate of coverage under a group health policy, records from medical care providers indicating health coverage, third party statements verifying periods of coverage, and any other relevant documents that evidence periods of health coverage.

DEFINITION OF “CREDITABLE COVERAGE” ▼

Creditable Coverage means coverage under any of the following plans: 1) a group health plan; 2) health insurance coverage; 3) Part A or Part B of Title XVIII of the Social Security Act (Medicare); 4) Medicaid (Title XIX of the Social Security Act), other than coverage consisting solely of benefits for the distribution of pediatric vaccines; 5) CHAMPUS (Chapter 55 of Title 10 U.S.C.); 6) a medical care program of the Indian Health Service or of a tribal organization; 7) a State health benefit risk pool; 8) the Federal Employees Health Benefit Plan; 9) a public health plan as defined in federal regulations; or 10) a health benefit plan Section 5(e) of the Peace Corp Act (22 U.S.C. Section 2504(e)).

Creditable Coverage does not include any combination of the following: 1) coverage for accident only or disability income insurance, or any combination thereof; 2) coverage issued as a supplement to liability insurance; 3) liability insurance, including general liability insurance and automobile liability insurance; 4) Worker’s Compensation or similar coverage; 5) automobile medical payment insurance; 6) credit-only insurance; 7) coverage for on-site medical clinics; or 8) other similar insurance coverage, specified in federal regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable Coverage does not include coverage for the following benefits if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan of coverage described above: 1) limited scope dental or vision benefits; 2) benefits for long term care; 3) nursing home care; 4) home health care; 5) community based care; 6) any combination of these plans; or 7) other similar limited benefit plans.

Creditable Coverage does not include the following plans if offered as independent benefits paid without regard to any other coverage: 1) coverage only for a specific disease or illness; or 2) hospital indemnity or other fixed indemnity insurance.

Creditable Coverage does not include the following coverage offered as a separate policy, certificate, or contract of insurance: 1) Medicare Supplemental insurance as defined by the Social Security Act; 2) coverage supplemental to CHAMPUS; 3) similar supplemental coverage provided under a group plan; or 4) Catastrophic insurance that supplements basic coverage.

6. HEALTH EVALUATION ▼

1. Are you within 6 months from the first day of the month in which you are first enrolled in Medicare Part B and you are age 65 or older? Yes No
2. Are you applying for Plan A? Yes No
3. Did you answer YES to any of the questions in Section 4? Yes No

If you answered YES to any of the questions above please skip ahead to Section 7, you do not need to complete the Health Screening Questionnaire on the following page.

6. HEALTH EVALUATION, CONTINUED ▼

HEALTH SCREENING QUESTIONNAIRE

Please read and check YES or NO for each question.

Part I

To the best of your knowledge and belief, within the last five (5) years, have you consulted or received treatment by a provider for any of the following:

- | | | |
|---|------------------------------|-----------------------------|
| 1. Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Insulin Dependent Diabetes Mellitus, Diabetes for which you take insulin | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Cirrhosis or other liver disorders/diseases | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Kidney disease or disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 5. Heart condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 6. Cerebrovascular disease, stroke | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 7. Hospitalized for any psychiatric or psychological disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 8. Alzheimer's or other brain disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 9. Circulatory condition or peripheral vascular disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 10. Emphysema or chronic obstructive pulmonary (lung) disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Part II

To the best of your knowledge and belief, have you been hospitalized for any condition within the last year? Yes No

If you do not pass medical underwriting, you can still enroll in Plan C or Plan F at the higher non-medically underwritten rate.

7. CONDITIONS OF ENROLLMENT (PLEASE READ THIS SECTION CAREFULLY) ▼

I hereby apply for an individual Supplement-65 policy for the plan checked. This application is subject to acceptance, exclusions and all other provisions contained in such policy. I agree to pay the charge for the policy as billed.

I have carefully read this application and agree to the terms specified herein. To the best of my knowledge, the foregoing statements are complete, true and correctly recorded, and are representations made to induce the issuance of, and form part of, the consideration for the policy for which I have applied.

This information is subject to verification. Failure to complete any section may delay the processing of your application and/or claims payment. If we determine that additional information is needed, you will receive an authorization to release that information. Failure to execute an authorization may result in the denial of your application for coverage.

**Please sign and date the application.
This application is not complete unless signed and dated.**

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

(Applicant's Signature – DO NOT PRINT) X _____ Date ____/____/____

▲ NOTE: MUST BE SIGNED ▲



Group Hospitalization and Medical Services, Inc.
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