Blue Cross Blue Shield of Oklahoma

Plan65

Blue Plan65 Select
Medicare Supplement

Blue Cross and Blue Shield of Oklahoma | P.O. Box 60545 | Oklahoma City, OK 73146-0545

YOU MAY APPLY FOR PLAN65 COVERAGE IF:

☒ You have Medicare Part A and B; **AND,**
☒ You are an Oklahoma resident; **AND,** ☒ You are age 65 or older.

FOR OFFICE USE ONLY	
REP. NO.	EFFECTIVE DATE

SELECT YOUR COVERAGE:

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan E ☐ Plan F ☐ Plan F (high deductible) ☐ Plan G ☐ Plan H ☐ Plan I ☐ Plan J ☐ Plan K ☐ Plan L ☐ *Blue* Plan65 *Select*

TELL US ABOUT YOURSELF:

LAST NAME OF APPLICANT	FIRST	MIDDLE	RESIDENCE PHONE
MAILING ADDRESS (STREET OR P.O. BOX, CITY, STATE, ZIP+4)			ALTERNATE PHONE

INFORMATION FROM YOUR MEDICARE IDENTIFICATION CARD YOUR 10-DIGIT CLAIM NUMBER	EFFECTIVE DATES PART A	 PART B	DATE OF BIRTH (MM / DD / YYYY)	SEX M F	SOCIAL SECURITY NUMBER
				☐ ☐	___ – ___ – ___

SELECT ONE PAYMENT OPTION:

DO NOT SEND MONEY NOW

A. Membership premium deducted from checking account every (select one):

☐ MONTH
☐ 3 MONTHS
☐ 6 MONTHS

Please complete the "Financial Institution Debit Authorization" section and attach your voided personal check.

B. Membership premium to be billed to my home address every (select one):

☐ MONTH
☐ 3 MONTHS
☐ 6 MONTHS

DO NOT SEND MONEY NOW.

C. This membership premium is to be billed to my Blue Cross and Blue Shield group (see your group benefits administrator/ employer for available coverage options).

NAME OF GROUP TO BE BILLED

GROUP NUMBER

FINANCIAL INSTITUTION DEBIT AUTHORIZATION

I hereby request and authorize Blue Cross and Blue Shield of Oklahoma to initiate debit entries to my account on or around the date payment is due.

THIS AUTHORITY IS TO REMAIN IN FULL FORCE AND EFFECT UNTIL BLUE CROSS AND BLUE SHIELD OF OKLAHOMA HAS RECEIVED WRITTEN NOTIFICATION FROM ME OF ITS TERMINATION IN SUCH TIME AND IN SUCH MANNER AS TO AFFORD IT A REASONABLE OPPORTUNITY TO ACT.

FINANCIAL INSTITUTION NAME AND ADDRESS	CITY	STATE	ZIP
TRANSIT ROUTING NUMBER (FROM LOWER LEFT HAND CORNER OF YOUR CHECK	ACCOUNT NUMBER	CHECKING ☐	SAVINGS ☐
NAME OF ACCOUNT HOLDER (PLEASE PRINT)	RELATIONSHIP TO APPLICANT		
SIGNATURE OF ACCOUNT HOLDER		TODAY'S DATE	

TELL US ABOUT YOUR PRESENT COVERAGE:

DO YOU NOW HAVE COVERAGE WITH BLUE CROSS AND BLUE SHIELD OF OKLAHOMA? ☐ YES ☐ NO	IF YES, YOUR CURRENT BLUE CROSS AND BLUE SHIELD OF OKLAHOMA SUBSCRIBER IDENTIFICATION NUMBER:

PLEASE TURN PAGE AND CONTINUE

RPL CODE

FOR OFFICE USE ONLY

GROUP NO.	F/C AGREEMENT NO.	F/C CODE	WVA CODE	WVA CODE EXP DATE	PROD. CODE	DIV CODE	CROSS-REF AGREEMENT NO.

COB CODE	INVOICE NO.	MSC CODE	EFF. DATE	CHAR. CODE DATE	SUB CHAR.	DEP. CHAR.	MINOR CHAR.	SUB DENT. CHAR	DEP. DENTAL CHAR

LOB	EFF. DATE	TERM. DATE	LOB	EFF. DATE	TERM. DATE	LOB	EFF. DATE	TERM. DATE

FOR AGENT USE ONLY	AGENT NAME	AGENT ID NO.

PLEASE TAPE CHECK HERE

PLEASE ANSWER THE FOLLOWING QUESTIONS

1. Have you been diagnosed with end-stage renal disease? . . . . . ☐ Yes ☐ No

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:

2. (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? ____/____/____
3. 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 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
4. (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
5. (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
6. 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?
   START ____/____/____ END ____/____/____
   (If you are still covered under the other policy, leave "END" date blank.)

STATEMENTS

(A) You do not need more than one Medicare supplement policy.

(B) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

(C) You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(D) 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 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.

Statements continue on next page

(E) 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 the suspension.

(F) 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).

AGREEMENTS AND SIGNATURE

- I understand that if I apply for Part A and B of Medicare and am not accepted, or at a future date lose Medicare entitlement, Plan65 will be of no value to me; therefore, it will be my responsibility to notify Blue Cross and Blue Shield of Oklahoma (hereafter referred to as BCBSOK) to terminate my Plan65.
- Any insurance agent, examining physician, or other person who knowingly and willfully makes a false or fraudulent statement or representation in or relative to any application for insurance, or who makes any such statement to obtain a fee, commission, money or benefit shall be guilty of a misdemeanor according to TITLE 36, SECTION 1204 of the Oklahoma State Statutes.
- I hereby apply for membership with BCBSOK as stated in this application. I agree that if my application is accepted, membership will not be effective until the date indicated in written notification by BCBSOK at time of acceptance.
- Physicians, hospitals and other institutions are hereby authorized and have my consent to release, disclose and furnish to BCBSOK for its review and retention in connection with my application for health coverage, all information, records or copies of records relating to my medical history and conditions, including, but not limited to, diagnosis, treatment, care, surgery, and the dates thereof, past, present and future.
- I understand BCBSOK may deny benefits for the treatment of any condition which is not correctly represented in this application, and has the right to cancel membership and coverage and to recoup any monies paid as benefits prior to a determination by the Plan that a condition required to be reported was not correctly represented.
- **Proof of Disclosure (for *Blue* Plan65 *Select* applicants only):** I acknowledge that I have carefully and completely read and understand the *Blue* Plan65 *Select* booklet and directory that were sent to me with this application. I am aware of and understand the restrictions of the *Blue* Plan65 *Select* provider directory.

WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, make any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

I CERTIFY THAT ALL STATEMENTS AND INFORMATION SET FORTH ARE TRUE AND CORRECT

APPLICANT'S SIGNATURE X _____ DATE SIGNED: _____

PROXY STATEMENT: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

Primary Applicant's Signature

X _____

Print Your Name as You Signed It: _____ Date Signed ____/____/____
Month Day Year

ACKNOWLEDGEMENT OF RECEIPT BY BLUE CROSS AND BLUE SHIELD OF OKLAHOMA

FOR OFFICE USE ONLY	DATE APPLICATION RECEIVED	EFFECTIVE DATE OF COVERAGE	SIGNATURE	DATE SIGNED

BlueCross BlueShield of Oklahoma

www.bcbsok.com

2.227 (02/06)