Regence

Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

Regence BlueShield of Idaho
1602 21st Avenue
Lewiston, ID 83501
Mail form to: PO Box 1106, MS-LB1
Lewiston, ID 83501
Fax form to: 1-877-369-3418

Medicare Insurance Number
(Medicare Claim Number)

Idaho Medicare Supplement (Medigap) Application

SPECIAL NOTICE

- You do not need more than one Medigap 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 Medigap policy.
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medigap 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 Medigap 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 Medigap 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 Medigap 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 Medigap policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medigap policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medigap 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 Medigap 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.
- Counseling services may be available in your state to provide advice concerning your purchase of Medigap insurance and concerning medical assistance through the state Medicaid program, including benefits as a qualified Medicare beneficiary (QMB) and specified low-income Medicare beneficiary (SLMB).

INSTRUCTIONS FOR COMPLETING YOUR APPLICATION

Thank you for selecting Regence BlueShield of Idaho (Regence) for your Medigap coverage. You must be age 65 or older and have both Medicare Part A and Part B to apply for these plans.

To assure prompt processing of your application, please be sure to:

1. Answer each required question completely **using ink.**
2. Copy the information from your Medicare Identification Card into Section 2 of this application.
3. Sign and date the statements in Section 10 of this application. If you choose our automatic bank withdrawal, complete Section 6.
4. If you need assistance completing this application, please contact our Sales Department at 1-888-Regence (1-888-734-3623) or contact your independent producer.

SECTION 1 - PLAN SELECTION

Choose ONE of these three standard plans or Regence Bridge Senior Selection:

☐ Regence Bridge Plan A ☐ Regence Bridge Plan C ☐ Regence Bridge Plan K

☐ Regence Bridge Senior Selection (Modified Plan F)

SECTION 2 - ENROLLMENT INFORMATION

Applicant Last Name	First Name, MI	Gender	Age

Height	Weight	Birthdate (mm/dd/yyyy)	Social Security Number

Medicare Insurance Number	Medicare Effective Dates (from your Medicare card):
	PART A (Hospital) _____ (mm/dd/yyyy)
	PART B (Physician) _____ (mm/dd/yyyy)

IDAHO RESIDENCE ADDRESS

To be eligible to apply for our Medigap plans, you must reside in our service area. A photocopy of a valid Idaho state driver's license, identification card, or current utility bill with name and address may be requested as proof of residency.

Residence Street Address	City, State, ZIP Code

Mailing Address (if different than residence street address)	City, State, ZIP Code

E-Mail Address (will not be disclosed outside of the company)

Email address

Home Phone Number (xxx) xxx-xxxx	Alternate Phone Number (xxx) xxx-xxxx	County

Your application is subject to review and approval by Regence. Complete applications received in our office by 5:00 PM Pacific Time on the last business day of the month will be eligible for an effective date of the first of the following month, unless otherwise indicated. Incomplete applications may receive a later effective date.

Requested Effective Date _____ (mm/dd/yyyy)

SECTION 3 - OTHER COVERAGE 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 Medigap insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medigap 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
(Please mark Yes or No with an "X")

Yes No

A. Did you turn 65 in the last 6 months? ☐ ☐

B. Will you be turning 65 in the next 6 months? ☐ ☐

C. Did you enroll in Medicare Part B in the last 6 months? ☐ ☐

If Yes, what is the effective date _____ (mm/dd/yyyy)

D. 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.)

If Yes, will Medicaid pay your rates for this Medigap contract? ☐ ☐

If Yes, do you receive any benefits from Medicaid **other than** payments toward your Medicare Part B premium? ☐ ☐

E. Have 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)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave **"End"** blank. ☐ ☐

If Yes: Start _____ (mm/dd/yyyy) **End** _____ (mm/dd/yyyy)

F. Have you recently lost coverage for medical assistance through the state Medicaid program? ☐ ☐

If Yes, what date did coverage end _____ (mm/dd/yyyy)

G. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medigap contract? ☐ ☐

H. Was this your first time in this type of Medicare plan? ☐ ☐

I. Did you drop a Medigap policy to enroll in the Medicare plan? ☐ ☐

J. Do you have another Medigap policy in force? ☐ ☐

If Yes, with which company and what plan do you have _____

_____

If Yes, was the effective date of your current policy prior to 6/1/10? ☐ ☐

If Yes, do you intend to replace your current Medigap policy with this contract? ☐ ☐

(Please complete Section 7 "Notice to Applicant Regarding Replacement of Medigap Insurance or Medicare Advantage".)

K. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan.) ☐ ☐

If Yes, with which company _____

If Yes, what kind of policy _____

If Yes, what are your dates of coverage under the other policy. If you are still covered under this plan, leave **"End"** blank.

Start _____ (mm/dd/yyyy) **End** _____ (mm/dd/yyyy)

Authorization signature required on page 11.

SECTION 4 - MEDIGAP PROTECTION PERIODS

*Regence Bridge Senior Selection (Modified Plan F)	Do I need to complete a Health Statement?			
Applying for plan:	**A**	**C**	***SS**	**K**
1. Your Medicare managed care plan or PACE program coverage ends because the plan is leaving the Medicare program, stops giving care in your area, or you move out of the plan's service area.	No	No	No	No
2. Your employer group health plan coverage ends.	No	No	No	No
3. Your Medigap insurance company goes bankrupt and you lose your coverage, or your Medigap policy coverage ends through no fault of your own.	No	No	No	No
4. You enrolled in a Medicare Part D plan during your initial enrollment period and were enrolled under a Medigap policy that covers outpatient prescription medications. Please enclose proof of enrollment in Medicare Part D.	No	No	No	No
5. You joined a Medicare Advantage or PACE program when you were first eligible for Medicare Part A (and you're enrolled in Medicare Part B). Within the first year of joining, you want to switch to Original Medicare.	No	No	No	No
6. You dropped a Medigap policy to join a Medicare Advantage plan, Medicare Select plan, or PACE program for the first time and now you want to leave. You have been in the plan for less than a year. A Health Statement is not required if you enroll in the same Medigap policy (with the same company) that you had previously.	No	No	No	No
7. You leave a Medicare Advantage plan or drop a Medigap plan because the company or its representatives haven't followed the rules, or mislead you.	No	No	No	No
8. You lost medical assistance through the state Medicaid program.	No	No	No	No

SECTION 5 - HEALTH STATEMENT

- Are you applying for coverage to start within the six-month period immediately following your enrollment in Medicare Part B or your 65th birthday? (This is your **open enrollment period.)** ☐ Yes ☐ No
- If you answered "Yes" to the above question, continue to Section 6. You do not need to answer any more questions in Section 5.
- If you answered "No" to above question, finish completing Section 5. Answer all of the questions in this section. **An incomplete application will be returned to you.**

Please Note: Congress has established a six-month open enrollment period for buying Medigap health insurance. The law guarantees that for six months immediately following enrollment in Medicare medical coverage Part B, individuals cannot be denied insurance due to health conditions.

Other than the circumstances listed above, there are some exceptions where, completing the following health history questionnaire may not be required. If you would like to verify if one of these exceptions applies to you please see page 4 section 4 otherwise, please complete the following questionnaire:

A. Within the last five years, have you had diagnosis, treatment, or advice relating to any of the following:

	Yes	No
1. Accident, injury, or deformity	☐	☐
2. Acquired Immune Deficiency Syndrome (AIDS) or related disease	☐	☐
3. Alcoholism or drug dependency	☐	☐
4. Anemia, blood disease, or leukemia	☐	☐
5. Arthritis or Rheumatoid Arthritis	☐	☐
6. Asthma or chronic bronchitis	☐	☐
7. Back trouble (recurrent or chronic)	☐	☐
8. Cancer or tumor	☐	☐
9. Confusion or Alzheimer's	☐	☐
10. Diabetes	☐	☐
11. Dizziness or headaches (frequent)	☐	☐
12. Epilepsy or convulsions	☐	☐
13. Ear, nose, or throat disorders	☐	☐
14. Eye disorder, glaucoma	☐	☐
15. Female disorders, fibroids, or excessive or irregular bleeding	☐	☐
16. Gallbladder	☐	☐
17. Heart or circulatory	☐	☐
18. High or low blood pressure	☐	☐
19. Intestines, bowel, or colon	☐	☐
20. Joint problems, including knee and other	☐	☐
21. Kidney or bladder	☐	☐
22. Liver disorder or hepatitis	☐	☐
23. Lung problems, chronic obstructive pulmonary disease, emphysema or oxygen use	☐	☐
24. Mental anxiety, emotional condition, or depression	☐	☐
25. Muscular Disorders, Dystrophies	☐	☐
26. Neurological disease or Parkinson's	☐	☐
27. Neuritis, chronic or recurrent numbness/tingling	☐	☐
28. Obesity (overweight)	☐	☐
29. Prostate or male disorder	☐	☐
30. Rectal disorder, hemorrhoids, or bleeding	☐	☐
31. Sciatica or chronic pain	☐	☐
32. Skin condition or disease, melanoma	☐	☐
33. Stroke	☐	☐
34. Stomach disorders, frequent or chronic heartburn	☐	☐
35. Thyroid or glandular	☐	☐
36. Ulcer (stomach or duodenal)	☐	☐
37. Varicose veins, phlebitis, or blood clots	☐	☐
38. Any other condition or disease not listed above (list below)	☐	☐

SECTION 5 - HEALTH STATEMENT (continued)

Please explain below any items that you checked "Yes" on the previous page.

Question Number	Year	Duration	Name and Nature of Injury, Disease, or Condition	Was Recovery Complete?	Name and Address of Physician

B. Have you been advised to have an operation that was not performed? ☐ Yes ☐ No

If "yes", please give full details, including name and address of physician _____

_____

C. Have you been hospitalized in the last 5 years or are you currently hospitalized or in an extended care facility? ☐ Yes ☐ No

If "yes", please explain below (use an extra sheet of paper if necessary).

Date of Hospitalization	Disease, Injury, or Condition	Name of Operation Performed, if any	Name and Address of Physician
(mm/dd/yyyy)			
(mm/dd/yyyy)			
(mm/dd/yyyy)			

D. Are you planning to be hospitalized within the next 6 months? ☐ Yes ☐ No

If "yes", please explain _____

_____

E. Have you taken any prescription medications within the past 12 months? ☐ Yes ☐ No

If "yes", please explain below (use an extra sheet of paper if necessary).

Medication	Prescribing Physician	Medical Condition	Still Taking?
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N
			Y or N

SECTION 6 – PREMIUM BILLING OPTIONS (if application is approved)

BILLING ADDRESS (complete only if billing should be sent to an address other than the Residence Street Address listed on the front of the application.)

Name	Relationship to Applicant

Address	City, State, ZIP Code

Please indicate which billing option you want to use. (If billing option is left blank, your policy will automatically default to Monthly Billing). A discount for premium invoice payment on quarterly, semi-annually, annually, or monthly by Electronic Funds Transfer (EFT) is available. Please contact our Sales Department at 888-REGENCE for further details.

☐ Monthly ☐ Annually
☐ Quarterly ☐ Semi-annually
☐ EFT (premium is automatically deducted from your bank account on the 5th of each month).

Note: If selecting EFT, please fill out the information below.

EFT is a simple and convenient way to keep your health coverage in force. If you select the EFT option of paying for your Regence health insurance, the payment will be deducted automatically on the 5th of each month. This will provide several advantages to you:

- Your payment will always be made on time (if funds are available in your account).
- You won't have to worry about your coverage accidentally lapsing due to overlooked payments.
- Your monthly bank statement will show a withdrawal notation. This will serve as receipt of payment.
- Claims will be paid promptly due to your policy always being paid current.

GETTING STARTED IS EASY:

1. **Complete,** date and sign the Electronic Funds Transfer Authorization information below.
2. **Write** "void" on one of your checks and return your "voided" check with this application (not a deposit slip). *For savings account please provide proof of ownership of the account.*

AUTHORIZATION TO MY BANK

☐ Checking Account
☐ Savings Account

As a convenience and on behalf of the Account Holder identified below, I/we hereby request and authorize you to pay and charge to the account identified below, checks or electronic debits drawn on the account by and payable to the order of Regence BlueShield of Idaho, Lewiston, ID. I/we agree that your rights to each such check or electronic debit shall be the same as if it were an actual check drawn on you and signed by me/us. This authority is to remain in effect until revoked by me/us in writing, and until you actually receive such notice, I/we agree that you shall be fully protected in honoring any such check. I/we further agree that if any checks or electronic debits be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance. A photocopy of this executed authorization shall be as valid as the original.

Financial Institution	Transit/Routing Numbers	Account Number

Account Holder's Name (please print)	Account Holder's Authorized Signature(s) as it appears on bank records	Date (mm/dd/yyyy)

SECTION 7 - NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDIGAP INSURANCE OR MEDICARE ADVANTAGE

Please review this section if you indicated in Section 3 of the application that you intend to terminate existing Medigap coverage or Medicare Advantage insurance and replace it with a policy to be issued by Regence. Your new policy will provide 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 Medigap coverage is a wise decision, you should terminate your present Medigap 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 ISSUER, PRODUCER (AGENT)

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medigap policy will not duplicate your existing Medigap coverage or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medigap 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 rates
☐ Fewer benefits and lower rates
☐ 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) _____

State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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 rates 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.

▶ _____	▶ _____
Producer's Signature*	Applicant's Signature
_____	_____
Producer's Regence Appointment Number	Applicant's Name (please print)
(mm/dd/yyyy)	
_____	_____
Date	Applicant's Medicare Insurance Number

**Producer signature not required if you do not have a Producer*

SECTION 8 - INSURANCE PRODUCER (AGENT) CERTIFICATION

If you have a producer, that producer may receive bonuses, commissions, administrative service fees, or other compensation, including non-cash compensation, from Regence. Incentives may be based on any of several factors, including the products you buy, your producer's volume of business with Regence, and the other services your producer provides you. For more information, please contact your producer.

FOR PRODUCER USE ONLY

I, (the producer) certify I have explained the eligibility provisions to the applicant. I have not made any statements about benefits, conditions or limitations of the contract except through written material furnished by Regence. I have informed the applicant that the effective date of coverage is assigned only by Regence and provided the Idaho Disclosure Information required.

I CERTIFY THAT THE INFORMATION SUPPLIED TO ME BY THE APPLICANT HAS BEEN TRULY AND ACCURATELY RECORDED HERE.

1. List any other medical or health insurance policies sold to the applicant _____

2. List the policies still in force _____

3. List the policies sold in the past 5 years that are no longer in force _____

Producer Name (please print or type)	Producer Phone Number (xxx) xxx-xxxx	Regence Appointment Number
Producer's Signature (Required) **X**		Date (Required) (mm/dd/yyyy)

PRODUCER: COLLECT NO PREMIUM WITH APPLICATION

SECTION 9 - CONSENT TO ELECTRONIC DISTRIBUTION

Regence is engaged in efforts to increase the use of technology and curb the use of paper. In support of those efforts, Regence has established a process under which communications to members can be posted to a secured account that a member establishes on myRegence.com, with e-mail notice provided to a member-supplied e-mail account when a new communication is posted.

By my signature and unless I have expressly rejected electronic distribution by marking the checkbox below, I consent, on behalf of myself and any covered dependents, to the electronic distribution of communications related to the coverage applied for and understand that:

- To access electronically distributed communications, I and each of my covered dependents will need to establish myRegence.com accounts for use on a system meeting the outlined requirements and I represent that we each have and will continue to have access to such a system or systems.
- Not all member communications are currently available electronically, but agree that my consent will apply to the following materials available, or as they become available, for electronic distribution, (i) notices of enrollment and/or effective date, (ii) acknowledgements of receipt of claims, requests for additional information related to claims and notices of associated delays in processing, and determinations on submitted claims, (iii) general informational disclosures required by law, including but not limited to notices of rights under the Women's Health and Cancer Rights Act, state patient protection acts, and privacy laws, (iv) communications regarding complaints, grievances, or appeals, including but not limited to acknowledgements of receipt, requests for additional information and notices of associated delays, and notices of determinations, (v) summaries of benefits and coverage and uniform glossary of terms, (vi) notices of benefit changes or policy modifications, (vii) renewal information, (viii) notices of discontinuation, (ix) notices of termination and continuation coverage rights, (x) certificates of creditable coverage, (xi) billing notices and statements.
- Until a type of communication can be distributed electronically, a paper copy will be provided.
- Once available in electronic form, any electronically distributed communications may be printed from the myRegence.com account where they are posted, or a paper copy of any particular communication may be requested at any time using myRegence.com or by contacting Regence Customer Service at the number provided on my ID card.
- I may change the e-mail address for receipt of notice of electronic distributions or withdraw consent (returning to paper distribution) at any time and without charge using myRegence.com or by contacting Regence Customer Service as described in the previous bullet.

The e-mail address for receipt of notice of electronic distributions is Email address

☐ I do not want electronic distribution. Unless my consent is not required for an electronic distribution, I elect to receive communications related to this coverage in a paper format.

SECTION 10 - CERTIFICATION, AUTHORIZATION AND SIGNATURE

Be sure to sign and date the application below. Signature applies to both "Certification of Completeness and Correctness" and "Authorization for Use and Disclosure of Protected Health Information":

CERTIFICATION OF COMPLETENESS AND CORRECTNESS

I affirm that the answers given in this application are true, complete, and correct. I am providing these answers as part of the application procedure required by Regence to enroll in their coverage. I understand that Regence will rely on each answer in making coverage and rating determinations. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. If coverage is rescinded for fraud or intentionally misleading statements, Regence will reimburse premium less any claims paid and will pursue reimbursement for claims paid exceeding any premium. I will promptly inform Regence in writing if anything happens before my coverage takes effect that makes this application incomplete or incorrect. I understand and agree that no coverage shall be in force until approved by Regence. Regence may phone me to clarify answers on this application. As the applicant, I understand I have the right to inspect the information in my file.

SECTION 10 - CERTIFICATION, AUTHORIZATION AND SIGNATURE (continued)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits, or as required by law.*

Health information requested or disclosed may be related to treatment or services performed by:

- a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
- a clinic, hospital, long-term care or other medical facility;
- any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or;
- an insurance carrier or health plan.

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes). A separate authorization will be required for psychotherapy notes.

I understand that if this application contains any material misstatements or omissions, Regence may deny coverage, modify or cancel coverage and/or take any other legal action available to us by law.

* For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Regence Consumer Privacy Notice. A copy is available on our Web site at **www.id.regence.com** or by telephone request at **1 (800) 365-3155.**

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES

(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of a conversation during a counseling session.)

SIGNATURE

Signature of applicant*	Date
X	(mm/dd/yyyy)

*** If signature by a personal representative of the member/enrollee please complete the following:**

Personal Representative's Name (please print) _____

Relationship to Individual _____ (Attach legal documentation if other than parent of a minor child)

If additional health information is required to qualify you for coverage, we may send you a separate authorization form for the purpose of obtaining medical information.

Do not send payment with your application. We will bill you upon acceptance of your application.

FOR OFFICE USE ONLY