

Medi-Pak Application for Coverage Change

Fully complete both sides of this application to avoid delays in processing. Be sure to sign your name next to the "X." Return this entire form in the postage-paid envelope provided. **SEND NO MONEY NOW.** You will be billed later.

1 PLEASE PRINT IN BLACK OR BLUE INK OR TYPE
 (FIRST NAME) (MIDDLE INITIAL) (LAST NAME) (TELEPHONE NO.)

2 (PERMANENT RESIDENCE STREET ADDRESS) (CITY) (STATE) (ZIP)

MAILING ADDRESS (only if different from your Permanent Residence Address)

3 (COUNTY) (DATE OF BIRTH) (AGE) (SEX) (YOUR SOCIAL SECURITY NO.)
 MO. DAY YR. MALE FEMALE

4 Medi-Pak Plan: (choose one) Plan A Plan B Plan C Plan D Plan F Plan G Plan J

5 Do you now have Blue Cross and Blue Shield Coverage? YES NO
 Your Blue Cross I.D. No. City/State of Blue Cross Plan

6 **MEDICARE INFORMATION:** You **must** have both Medicare Hospital (Part A) and Medical (Part B) coverage to apply for Medi-Pak. Please give your Medicare information exactly as it appears on the red, white and blue Medicare card you received from Social Security.

MEDICARE CLAIM NUMBER: □□□□□□□□□□	HOSPITAL (PART A) EFFECTIVE DATE: MO. DAY YR.	MEDICAL (PART B) EFFECTIVE DATE: MO. DAY YR.
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7 How do you want to be billed? (Check one only.) Monthly Bank Draft Quarterly

8 Please answer ALL of the following health questions.

UNDER OPEN ENROLLMENT, HEALTH QUESTIONS ARE <u>NOT</u> REQUIRED TO BE ANSWERED.	YES	NO
1. Are you Medicare disabled?..... If "yes," please indicate disability condition(s)_____	1. <input type="checkbox"/>	<input type="checkbox"/>
2. Do you have a pacemaker?.....	2. <input type="checkbox"/>	<input type="checkbox"/>
3. Are you now a patient in a hospital or nursing home?.....	3. <input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever been declined or rated for the issuance of life, accident or health insurance?..... If "yes," please explain:_____	4. <input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had any diagnosis of or been advised to have treatment for:		
a. Disease or disorder of the heart, circulatory system or high blood pressure or stroke?.....	5a. <input type="checkbox"/>	<input type="checkbox"/>
b. Disease or disorder of the lungs or respiratory system?.....	5b. <input type="checkbox"/>	<input type="checkbox"/>
c. Disease or disorder of the kidneys, liver, gallbladder, intestines, rectum, stomach or other vital organs?.....	5c. <input type="checkbox"/>	<input type="checkbox"/>
d. Diabetes or high blood sugar? If yes, date of onset _____	5d. <input type="checkbox"/>	<input type="checkbox"/>
e. Mental incapacitation, Alzheimer's disease, mental disease, depression or psychiatric treatment?.....	5e. <input type="checkbox"/>	<input type="checkbox"/>
f. Physical incapacitation, epilepsy, Parkinson's disease or disorder of the nervous system?.....	5f. <input type="checkbox"/>	<input type="checkbox"/>
g. Cancer or malignancy?.....	5g. <input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE USE ONLY (DO NOT WRITE IN THIS SPACE)

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	I.D.#	EFFECTIVE DATE	PKG	AD & D:
Date_____ ICU_____	GROUP #			N/C N/I \$2 \$3 \$5

HOME OFFICE ENDORSEMENTS:

8 Continued from page 1

YES NO

- h. Disease or disorder of the blood, glands or skin?.....5h.
- i. Arthritis, paralysis, disease or disorder of the muscles, bones or joints?.....5i.
- 6. Have you consulted a physician or received hospital (inpatient or outpatient care) or rehabilitation services during the past five years?.....6.
- 7. Have you ever had or been advised to have treatment for any condition not listed?.....7.
- 8. Are you currently taking medication prescribed by a doctor? (If "yes," list below in section 9)..... 8.
- 9. Height _____ Weight _____
- 10. Have you used any form of tobacco within the last 12 months?.....10.

Acceptance or rejection of your application is subject to our review of the above medical questions and enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage.

Applications cannot be processed unless all questions are answered.

9 If you answered yes to any question in section 8, complete this section.

(Attach additional sheet, if necessary, to complete section 9)

QUESTION NO.	CONDITION	TYPE OF TREATMENT/MEDICATION	DATE OF FIRST VISIT	DATE OF LAST VISIT	DEGREE RECOVERY			NAME AND ADDRESS OF PHYSICIAN
					NONE	PARTIAL	FULL	

PRESCRIPTION DRUGS (LIST NAMES AND DATES TAKEN):

10 IMPORTANT: PLEASE READ AND SIGN

SEND NO MONEY WITH THIS APPLICATION. YOU WILL BE BILLED.

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 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 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 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.
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).

In signing below, I represent that the statements and answers given on this application and any signed and dated addendum to this application are true, complete and correctly recorded. I authorize and release to Arkansas Blue Cross and Blue Shield Title XVIII Medicare claims information needed to coordinate benefits with this policy at any time I am eligible for Medicare benefits. I (a) agree that this authorization shall be valid without time limit; (b) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me upon request.

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

X _____ Date

Sign Here (must be signed by proposed insured)

Date