How to apply for a Blue Cross Blue Shield of Arizona
MEDICARE SUPPLEMENT PLAN

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Thank you for selecting Blue Cross® Blue Shield® of Arizona (BCBSAZ). If you have questions, need assistance completing the application, or need additional application forms, please call your health insurance producer or BCBSAZ at **1-888-264-1733, TTY: 711.**

You are eligible to apply if:

- In general, you are 65 years* of age or older; and
- You are enrolled in Medicare Parts A and B; and
- You reside in Arizona, if you are applying for Senior Security; or
- You reside in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, or Santa Cruz County, if you are applying for Senior Preferred.

You are *not* eligible to apply for a BCBSAZ Medicare supplement plan if:

- You are receiving disability benefits and are under age 65.
- You are not a resident of Arizona.
- You already have a Medicare supplement or Medicare Advantage policy and do not intend to replace it with this plan.
- **You meet any of the conditions below, unless you are entitled to Guaranteed Issue rights,** as described in the CMS brochure, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," which BCBSAZ makes available with this application. You may contact the State Health Insurance Assistance Program at 602-542-6595, 1-800-432-4040 Statewide, or TTY Line at 602-542-6366 for information regarding plans that may be available to you if you have end-stage renal disease.
  - You are receiving or have been advised to receive kidney dialysis.
  - **You have end-stage renal disease (ESRD).**
  - You have been diagnosed with a kidney disease that may require kidney dialysis.
  - You have had an inpatient admission into a hospital within the last 90 days.
  - You are currently in the process of a medical work-up or treatment for an unresolved condition related to any of the following:
    - Organ transplant, back or spine surgery, joint replacement, surgery for cancer, heart surgery, vascular surgery

Here's how to apply: *Please use dark ink. (Do not use red ink.)*

1. Complete, sign, and date all sections as indicated by signature boxes.
2. If you are applying for Senior Preferred Medicare Select coverage, please read the Senior Preferred subsection in the Acknowledgements.
3. If you would like the convenience of automatic withdrawal for billing purposes, be sure to complete, sign, and date the Autopay Authorization.
4. If you would like BCBSAZ to share your personal information with another individual (such as a spouse, child, or producer), please read the instructions and complete the Confidential Information Release Form included as part of this application. **This is an optional form.**
5. Mail the entire application form to: **Attn: Blue Cross Blue Shield of Arizona**
   P.O. Box 81049
   Phoenix, AZ 85069-1049

   We will return a copy to you. **Do not send any premium.** (If your application is approved, you will be billed when a contract is issued to you.)

*You may apply during the time period when you are enrolled in Medicare Parts A and B and you are age 64, if there are no more than 90 days until the first day of the month in which you turn 65.

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Application for
MEDICARE SUPPLEMENT COVERAGE

BlueCross BlueShield Arizona

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1. Your Choice of Coverage

Senior Security	**Senior Preferred** (Medicare Select)	**Senior Security**	**Senior Preferred** (Medicare Select)
Available throughout Arizona Plan: ☐ A ☐ D ☐ G ☐ N	Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, and Santa Cruz counties Plan: ☐ D ☐ G ☐ N	Plan: ☐ C† ☐ F†	Plan: ☐ C†

Your Desired Effective Date

1st day of (month)

☐ Jan	☐ Mar	☐ May	☐ July	☐ Sept	☐ Nov
☐ Feb	☐ April	☐ June	☐ Aug	☐ Oct	☐ Dec

2. Applicant Information

Name (First/Middle Initial/Last)

Are you an Arizona resident? ☐ **Yes** ☐ **No**

Physical Address

City	State	ZIP

Mailing Address (if different from Physical address)

City	State	ZIP

Telephone Number	Email address*

Date of Birth (MM/DD/YYYY)	Gender	
/ /	☐ M ☐ F	*By providing an email address in this application, I agree to receive communications electronically from BCBSAZ at that email address.

Do you currently have Blue Cross Blue Shield of Arizona coverage? ☐ **Yes** ☐ **No**

If Yes, who is coverage with?

Contract Holder's Name	BCBSAZ Identification No.

Have you used tobacco products in the past 12 months? ☐ **Yes** ☐ **No**

Medicare Number and Effective Dates. Please copy this information exactly as it appears on your Medicare Card.

Medicare Number	Part A (Hospital) Coverage Starts (MM/DD/YYYY)	Part B (Medical) Coverage Starts (MM/DD/YYYY)
	/ /	/ /

†Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

BlueCross BlueShield Arizona

3. Eligibility & Prior 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 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.

I. (a) Did you turn age 65 in the last 6 months **OR** will you turn 65 in the next 90 days? . . . . . ☐ **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 (MM/DD/YYYY) _____ /_____/_____

II. (a) Are you covered for medical assistance through a 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**

(b) If yes, will Medicaid pay your premiums for this Medicare Supplement policy? . . . . . ☐ **Yes** ☐ **No**

(c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? . . . . . ☐ **Yes** ☐ **No**

III. (a) Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, Medicare Advantage or Medicare HMO or PPO)? . . . . . ☐ **Yes** ☐ **No**

If yes, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

START _____/_____/_____ (M M/ D D / Y Y Y Y) END _____/_____/_____ (M M/ D D / Y Y Y Y)

(b) Please indicate the reason for terminating the Medicare policy (select one):

☐ I moved out of the service area
☐ The plan stopped participating in Medicare or is no longer offered where I live
☐ Other

(c) 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**

(d) Was this your first time in this type of Medicare plan? . . . . . ☐ **Yes** ☐ **No**

(e) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? . . . . . ☐ **Yes** ☐ **No**

IV. (a) Do you have another Medicare Supplement policy in force? . . . . . ☐ **Yes** ☐ **No**

(b) If so, with what company? _____
What plan do you have? _____

(c) If so, do you intend to replace your current Medicare Supplement policy with this new Medicare Supplement policy**? . . . . . ☐ **Yes** ☐ **No**

(d) Have you lost coverage from another Medicare Supplement policy within the last 63 days? . . . ☐ **Yes** ☐ **No**

End Date _____/_____/_____
(M M/ D D / Y Y Y Y)

If yes, please indicate the reason for terminating the Medicare supplement policy (select one):

☐ I moved out of the service area
☐ The plan stopped participating in Medicare or is no longer offered where I live
☐ Other

*****If you answered Yes to questions III(c) or IV(c) and an agent is assisting you in purchasing this plan,*** be sure that your agent provides you with a completed "Notice to Applicant" form, located at the end of this application.

V. (a) Have you had coverage under any other health insurance within the past 63 days? (for example, an employer group, union, or individual non-Medicare plan)? . . . . . ☐ **Yes** ☐ **No**

(b) If so, with what company? _____
Carrier customer service #_____

By providing this # you authorize BCBSAZ to contact your prior carrier to verify eligibility/prior coverage.

What type of policy do you have? _____

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

START _____/_____/_____ (M M/ D D / Y Y Y Y) END _____/_____/_____ (M M/ D D / Y Y Y Y)

(d) Do you intend to replace this insurance with a new Medicare Supplement policy? . . . . . ☐ **Yes** ☐ **No**

4. Medical Questions

If you answered Yes to questions I (a) or (b) above, you are in your Open Enrollment Period and qualify for guaranteed acceptance. Please skip this section.

Please answer all questions below by marking Yes or No.

1. Have you been diagnosed with ESRD, or any other kidney disease that may require kidney dialysis? . . ☐ **Yes** ☐ **No**
2. Have you had an inpatient admission to a hospital within the last 90 days? . . . . . ☐ **Yes** ☐ **No**
3. Are you currently in the process of a medical work-up or treatment for an unresolved condition related to any of the following?
   a. Organ Transplant . . . . . ☐ **Yes** ☐ **No**
   b. Back or Spine Surgery. . . . . ☐ **Yes** ☐ **No**
   c. Joint Replacement . . . . . ☐ **Yes** ☐ **No**
   d. Surgery for Cancer . . . . . ☐ **Yes** ☐ **No**
   e. Heart Surgery . . . . . ☐ **Yes** ☐ **No**
   f. Vascular Surgery . . . . . ☐ **Yes** ☐ **No**

If you answered yes to any of the questions above, you are NOT eligible for these plans at this time. If your health status changes in the future, allowing you to answer No to all the questions in this section, please submit an application at that time.

4. Have you been in a skilled nursing facility, long-term care facility, rehabilitation facility, or nursing home within the last 2 years? . . . . . ☐ **Yes** ☐ **No**
5. Have you been advised within the last 2 years, to have any type of surgery that is planned, scheduled, or pending? . . . . . ☐ **Yes** ☐ **No**
6. **Within the past 2 years, have you been diagnosed or treated for any of the following conditions, as determined by a medical professional?** ***If you are unsure, please consult your physician.***
   a. Cancer or tumors (other than skin cancer) . . . . . ☐ **Yes** ☐ **No**
   b. Alcoholism or substance abuse requiring inpatient or outpatient treatment . . . . . ☐ **Yes** ☐ **No**
   c. Psychological or mental health disorder(s) including hospitalization(s) . . . . . ☐ **Yes** ☐ **No**
   d. AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV) . . . . . ☐ **Yes** ☐ **No**
   e. Alzheimer's disease, dementia, or cognitive impairment. . . . . ☐ **Yes** ☐ **No**
   f. Rheumatoid arthritis, myasthenia gravis, systemic lupus erythematosus (SLE), multiple sclerosis, amyotrophic lateral sclerosis (ALS). . . . . ☐ **Yes** ☐ **No**
   g. Diabetes with any of the following: Circulatory problems, kidney problems, or retinopathy . . . . . ☐ **Yes** ☐ **No**
   h. Emphysema, chronic obstructive pulmonary disease (COPD), or tuberculosis, (not including asthma) . ☐ **Yes** ☐ **No**
   i. Cirrhosis, hepatitis B, or hepatitis C . . . . . ☐ **Yes** ☐ **No**
   j. Parkinson's disease . . . . . ☐ **Yes** ☐ **No**
   k. Osteoporosis with osteoporosis-related fractures . . . . . ☐ **Yes** ☐ **No**
   l. Degenerative Bone Disease . . . . . ☐ **Yes** ☐ **No**
   m. Congestive Heart Failure (CHF), Cardiomyopathy, Carotid Artery Disease (CAD), Peripheral Vascular Disease (PVD), Aneurysm, Arteriosclerosis or Atherosclerosis, or Artery or Vein Blockage . . ☐ **Yes** ☐ **No**

n. Heart attack or stroke (including TIA); cardiac surgery (including coronary bypass surgery or angioplasty); rhythm disorders requiring a pacemaker; Atrial Fibrillation or Atrial Flutter; or Ventricular Tachycardia . . . . . ☐ **Yes** ☐ **No**

o. Chronic Pancreatitis . . . . . ☐ **Yes** ☐ **No**

p. Esophageal Varices . . . . . ☐ **Yes** ☐ **No**

q. Amputation due to disease . . . . . ☐ **Yes** ☐ **No**

r. Spinal stenosis . . . . . ☐ **Yes** ☐ **No**

s. Paraplegia, Quadriplegia, or Hemiplegia . . . . . ☐ **Yes** ☐ **No**

t. Macular Degeneration . . . . . ☐ **Yes** ☐ **No**

5. Important Information for Your Protection

I. You do not need more than one Medicare Supplement policy.

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

III. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.

IV. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your BCBSAZ 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.

V. 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.

VI. Counseling services may be available in Arizona to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits such as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

6. Acknowledgements—read this section and sign at the end

I. I have carefully read all of this application form and the information I provided. I understand and agree that it will be part of my contract with Blue Cross Blue Shield of Arizona (BCBSAZ).

II. I understand and agree that:

- The information I've provided is material to BCBSAZ's decision to offer healthcare coverage.
- BCBSAZ will rely on the accuracy of the information to determine my eligibility for coverage and the premium rate I will pay for that coverage.
- If BCBSAZ discovers a material misrepresentation or omission after issuing coverage, BCBSAZ may rescind the contract and declare it null and void as of the effective date of coverage, or adjust my premium rate to the rate I should have paid based on accurate information, retroactive to the effective date of coverage.
- Coverage will be effective only after BCBSAZ has accepted and reviewed this application and assigned an effective date.
- Coverage will be subject to the benefits, limitations, and provisions of the BCBSAZ benefit plan, regardless of any other coverage I may have had in the past.

III. I acknowledge that I have received an Outline of Coverage for BCBSAZ's Senior Security and Senior Preferred plans.

IV. I acknowledge that I have received a copy of the "Guide to Health Insurance for People with Medicare."

V. I understand that:

- BCBSAZ sells health and dental coverage products either directly or through independent licensed insurance producers.
- Commission payments to producers are one of the costs factored into premiums, but BCBSAZ's premium calculation is not based on whether a product is sold directly or by a producer.
- BCBSAZ generally pays a commission to the producer of record or permitted assignee until this contract is terminated or the contract holder terminates his/her relationship with the producer or the producer becomes ineligible.
- BCBSAZ producer contracts require the producer to give me information on the producer's commission rate with BCBSAZ. I can also get more detailed information about producer commission and compensation paid to BCBSAZ licensed inside sales representatives for sales of BCBSAZ products at **azblue.com/medicare** or by calling BCBSAZ at **480-389-2712.**

VI. Medicare Select Acknowledgment

If you are enrolling in a Senior Preferred Medicare Select Plan, you acknowledge that you have received the following information and understand the restrictions of the Senior Preferred benefit plan:

- An Outline of Coverage comparing the Senior Preferred Medicare Select benefit plan and premium with the Senior Security benefit plans and premiums, which includes the following:
  - A description of benefits available when Senior Preferred or non-Senior Preferred providers are used
  - A description of coverage for emergency and out-of-service-area care
  - A description of limitations on referrals to non-Senior Preferred providers
  - A description of my right to purchase a Senior Security plan
  - A description of BCBSAZ's quality assurance program and complaint and grievance procedure
- A Senior Preferred provider directory

VII. I give permission for BCBSAZ to call me at the phone number(s) provided in this application to provide information and/or discuss matters related to any benefit plan that I purchase, as well as health and wellness information that is related to any such benefit plan.

All applicants must sign and date the signature box below to indicate agreement with the acknowledgments.

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

7. To be completed by the producer:

Producers shall list any other health insurance policies sold to the applicant.

I. Have you sold any other health insurance policies to the applicant, either in force or within the last five (5) years? . . . . . ☐ **Yes** ☐ **No**

II. If Yes, list all health insurance policies sold to the applicant that are still in force.

_____

_____

III. List all health insurance policies sold to this applicant in the past five years that are no longer in force.

_____

_____

_____

Producer's Signature_____Date_____/_____/_____
(M M/ D D / Y Y Y Y)

SPACE BELOW FOR PRODUCER USE ONLY	
PRODUCER NAME, MAILING ADDRESS, AND PHONE	**NATIONAL PRODUCER NUMBER**

BlueCross BlueShield Arizona

8. Payment

Please select a monthly method of payment

☐ Autopay Electronic Bank Draft *Please complete the Autopay Authorization included with this application*

☐ Paper bill

Save the trouble of writing us a check. With Autopay, there's no paper bill to keep track of, no check to write, and nothing to mail. Instead, your premium is automatically withdrawn from your checking or savings account.

If the deduction for your first month's premium is delayed, the initial amount withdrawn may be more than one monthly premium.

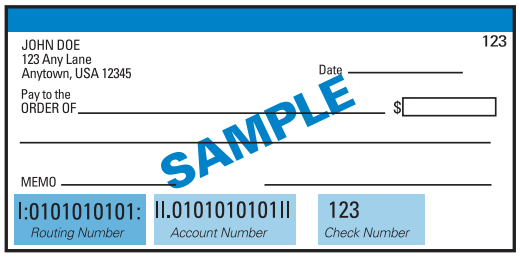
Electronic Billing Information

Pay your premiums the convenient way with Autopay.

Please debit my: ☐ Checking ☐ Savings

ROUTING TRANSIT NUMBER _____

ACCOUNT NUMBER _____



For the Financial Institution

- I authorize BCBSAZ to start an automatic periodic charge to my checking or savings account as noted above. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.
- I want this charge to continue automatically until I write BCBSAZ telling them to discontinue my Autopay service. I agree to allow a reasonable time for discontinuation of Autopay withdrawals, and I understand BCBSAZ will refund premium that may be due to me based on the time necessary to terminate Autopay withdrawals.
- I understand BCBSAZ and my financial institution have the right to discontinue this service if either elects to do so.
- I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month, or for twice the amount the following month. My BCBSAZ coverage will be terminated if there are insufficient funds in two consecutive drafts.
- I have read and agree to abide by the Autopay conditions as outlined on this authorization form. I understand any applicable refund of monies due will be released 30 days after the last draft date.

Applicant Name (please print)_____

Authorized Signature on Account _____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

ACKNOWLEDGEMENT AND ATTESTATION
for Medicare Supplement 5% Household Discount

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

MEMBER 1	First Name	Last Name		Middle Initial
	Member ID Number *(leave blank if Member ID Number has not been issued)*			
	Physical Street Address	City	State	ZIP
MEMBER 2	First Name	Last Name		Middle Initial
	Member ID Number *(leave blank if Member ID Number has not been issued)*			
	☐ Check here if Member 2 physical street address is the same as Member 1 listed above			

Acknowledgement and Attestation:

Blue Cross Blue Shield of Arizona ("BCBSAZ") offers a 5% household discount to effective BCBSAZ Medicare Supplement policy holders residing at the same residential address. Only Medicare Supplement policies qualify. Commercial, Individual, Group, standalone Part D prescription drug and Medicare Advantage policies do not qualify for the household discount. Assisted living facilities, group homes, and other non-residential settings do not qualify for the discount. BCBSAZ may request additional documentation from any person applying for or receiving the discount.

I attest to the best of my knowledge that the individuals listed above are each enrolled in a Medicare Supplement policy issued by BCBSAZ and meet all other eligibility requirements for the BCBSAZ Medicare Supplement 5% household discount. I understand and acknowledge that BCBSAZ may periodically audit for continued discount eligibility, and I agree to provide any additional documentation requested by BCBSAZ within the requested timeframe to verify eligibility.

BCBSAZ reserves the right, upon thirty (30) days' notice to the members listed above, to terminate the 5% household discount for any of the following reasons: (1) the household discount program has been discontinued; (2) the members, for any reason, voluntarily or involuntarily, no longer live at the same address; (3) the members, for any reason, voluntarily or involuntarily, are no longer current members of a BCBSAZ Medicare Supplement plan.

If an active Medicare Supplement policy holder becomes deceased while enrolled in the household discount program, the 5% household discount will continue to be applied to the surviving policy holder's premium through the policy end date, in accordance with payment terms and policy eligibility.

Termination of the 5% household discount program does not terminate a member's individual policy with BCBSAZ.

_____ _____

Applicant/Member 1 Signature Date

_____ _____

Applicant/Member 2 Signature Date

Instructions for Completing the CONFIDENTIAL INFORMATION RELEASE FORM

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

Please fill out this form if you would like Blue Cross® Blue Shield® of Arizona (BCBSAZ) to share your information with the person or company you mention on the form. **Each member who is 18 or older has to fill out and sign a separate form.**

Why Might You Want BCBSAZ to Share Your Records?

BCBSAZ has to keep your information private. BCBSAZ needs this form if you want us to share your records with:

- Your spouse, parent, or child, so they can discuss claims questions with BCBSAZ.
- Your producer, after you sign up for a health plan so he/she can help with claims.
- Your lawyer, for an injury case.

How to Fill Out This Form

Tell Us What Records We Can Share: Check at least one box.

Tell Us Whose Records We Can Share: Write the name of the BCBSAZ member this form is for. This is usually your name.

Tell Us Who Can Get the Records: This might be the name of a person, or it could be the name of a business, like a medical group, if you don't want us to send the records to a specific person.

Tell Us Why You Want Us To Share Your Records: Check at least one box. If you don't have a special reason, please check "Other reason" and write in "At My Request."

Change My Records: Tell us if the person can change your address or bank account information. Note: This part of the form is optional.

Tell Us When to Stop Sharing Your Information: You must check at least one box. If you check the box by "The date marked here," please write the date we should stop sharing your information with this person or business. If you don't have a specific date, check the 90-day box. No matter which box you check, if you change your mind, you can also ask us to stop sharing your information at any time by writing to our Privacy Office.

BCBSAZ Member's ID Number: Enter the BCBSAZ ID number of the person whose records will be shared. If you do not know the ID number, use the Social Security number.

Signature: Print and sign your name and date the form.

Group Name and Number: If you have coverage through your work, you are in a Group plan. Enter the name and number of your Group health plan if this applies.

Representative's Name/Signature: If you are signing the form because you are acting for someone else, fill in your name, and sign and date the form. Include copies of the legal papers that apply.

Questions? For questions about the form, please call the Privacy Office at **602-864-2255 or 1-800-232-2345,** extension **2255. (TTY: 711).**

CONFIDENTIAL INFORMATION RELEASE FORM

BlueCross BlueShield Arizona

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Use this form to let a person or firm get your information, except HIV information. We have a different form for HIV information. You can also use this form to let them change your address or bank information. Even if you don't sign this form, Blue Cross® Blue Shield® of Arizona (BCBSAZ) will still pay your claims, sign you up for our plan, and let you be eligible for benefits. This form is not required.

Tell Us What Records We Can Share: BCBSAZ can give out what is marked below. Some of these records may have details about contagious diseases, alcohol and drug abuse treatment, and genetic testing *(check all that apply):*

- ☐ Application, enrollment, eligibility information
- ☐ Claims/Explanation of Benefits information
- ☐ Precertification information
- ☐ Billing/payment information
- ☐ Medical or dental records, procedure & diagnosis codes
- ☐ Account information
- ☐ Other *(please explain)* _____

Tell Us Whose Records We Can Share:			
Tell Us Who Can Get the Records:			
Name	Company Name		
Address	City	State	ZIP Code

Note: If you tell us to share your records with someone, the person who gets your records may not keep them private. Your records won't be protected anymore under federal privacy laws.

Tell Us Why You Want Us to Share Your Records *(check all that apply):*

☐ To help get a healthcare policy ☐ To help with claims or payments ☐ At my request

☐ Other reason *(please explain):*

Change My Records:	
I also want to let (name):	☐ Change my address ☐ Update my bank information

Tell Us When to Stop Sharing Your Information:

☐ 90 days after the health plan ends ☐ The date marked here (MM/DD/YYYY): ☐ No expiration

You may tell us to stop sharing your records at any time. **If you want us to stop sharing, write to us at:**
BCBSAZ Privacy Office, Mail Stop C300, P. O. Box 13466, Phoenix, AZ 85002-3466.
If you tell us to stop sharing, it will not change what BCBSAZ shared before you told us to stop.

Member Name	BCBSAZ Member's Identification Number
Member Signature	Date Signed (MM/DD/YYYY)
Group Name (if this applies)	Group Number (if this applies)
Representative's Name*	Relationship to BCBSAZ Member

*If you are asking us to share records for someone other than yourself, please tell us why you can do this. Also, attach a copy of any legal paper(s) that apply.

Please send us your filled-out, signed form by either mail or fax.

Mail: BCBSAZ
Attention: Enrollment
P.O. Box 13466 | Phoenix, AZ 85002-3466
Fax: 602-864-4041

If you'd like a copy of your signed form, call the Privacy Office at **602-864-2255** or **1-800-232-2345, ext. 2255 (TTY: 711).**

OFFICE COPY

Please return this copy with your application

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

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

Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

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

According to your application, you intend to lapse or otherwise terminate existing Medicare supplement contract or Medicare Advantage insurance and replace it with a contract to be issued by Blue Cross Blue Shield of Arizona. Your new contract to be issued by Blue Cross Blue Shield of Arizona will provide thirty (30) days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you have now. 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 contract.

Statement to Applicant by Issuer, Agent, Producer or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract 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 contract 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. Explain reasons for disenrollment. _____

_____

☐ Other. (Please specify) _____

If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application which requests that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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 contract and are sure you want to keep it.

_____

(**Signature of Agent, Producer, or Other Representative**)

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

CUSTOMER COPY

Please keep this copy for your records.

BlueCross BlueShield Arizona

An Independent Licensee of the Blue Cross Blue Shield Association

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

Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

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

According to your application, you intend to lapse or otherwise terminate existing Medicare supplement contract or Medicare Advantage insurance and replace it with a contract to be issued by Blue Cross Blue Shield of Arizona. Your new contract to be issued by Blue Cross Blue Shield of Arizona will provide thirty (30) days within which you may decide without cost whether you desire to keep the contract. 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 contract.

Statement to Applicant by Issuer, Agent, Producer or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement contract 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 contract 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. Explain reasons for disenrollment. _____

_____

☐ Other. (Please specify) _____

If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application which requests that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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 contract and are sure you want to keep it.

_____

(**Signature of Agent, Producer, or Other Representative**)

Applicant's Signature_____ Date_____/_____/_____
(M M/ D D / Y Y Y Y)

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We provide free aids and services to people with disabilities to communicate effectively with us, such as qualified interpreters and written information in other formats such as large print and accessible electronic formats. We also provide free language services to people whose primary language is not English, such as qualified interpreters and written information in other languages. If you need these services call **480-566-2868 (TTY: 711).**

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **480-566-2868 (TTY: 711).**

Navajo: Díí baa akó nínízin: Díí saad bee yáníltí' go Diné Bizaad, saad bee áká' ánída' áwo' dęę, t'áá jiik'eh, éí ná hóló, kojį hódíílnih **480-566-2868** (TTY: **711**).

BlueCross BlueShield Arizona

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