Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: Revised Medipak Applications	SERFF Tr Num: ARBB-127893340	State: Arkansas
TOI: MS06 Medicare Supplement - Other	SERFF Status: Closed-Approved-Closed	State Tr Num: 50469
Sub-TOI: MS06.000 Medicare Supplement - Other	Co Tr Num: MPAPP-DR,MPAPP-AG,MPHI R01/12	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Stephanie Fowler
	Authors: Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney	Disposition Date: 12/13/2011
	Date Submitted: 12/13/2011	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Applications
Project Number: MPAPP-DR, MPAPP-AG, MPHI R01/12
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Evelyn Laney

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Arkansas is state of domicile.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 12/13/2011
State Status Changed: 12/13/2011
Created By: Evelyn Laney
Corresponding Filing Tracking Number:

Filing Description:

Attached please find forms MPAPP-DR, MPAPP-AG, and MPPHI (R01/12) for your review and approval if indicated. In these revised forms under “Authorization to Disclose Protected Health Information”, we have added pharmacy benefits manager, and the statement “I understand that information re-disclosed may no longer be protected by federal privacy regulations. “ We have also added new language to the bank draft form which states “I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.”{

I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19.
Please feel free to contact me at 378-2165 with any questions you may have.

Company and Contact

Filing Contact Information

Evelyn Laney, Senior Compliance Analyst exlaney@arkbluecross.com
320 West Capitol, Ste 211 501-378-2165 [Phone]
Little Rock, AR 72201 501-378-2975 [FAX]

Filing Company Information

Arkansas Blue Cross and Blue Shield	CoCode: 83470	State of Domicile: Arkansas
601 S. Gaines Street	Group Code:	Company Type:
Little Rock, AR 72201	Group Name:	State ID Number: N/A
(501) 378-2967 ext. [Phone]	FEIN Number: 71-0226428	

Filing Fees

Fee Required?	No
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	$0.00	12/13/2011	

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	12/13/2011	12/13/2011

Disposition

Disposition Date: 12/13/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*ARBB-127893340*	*State:*	*Arkansas*
Filing Company:	*Arkansas Blue Cross and Blue Shield*	*State Tracking Number:*	*50469*
Company Tracking Number:	*MPAPP-DR,MPAPP-AG,MPHI R01/12*		
TOI:	*MS06 Medicare Supplement - Other*	*Sub-TOI:*	*MS06.000 Medicare Supplement - Other*
Product Name:	*Revised Medipak Applications*		
Project Name/Number:	*Applications/MPAPP-DR, MPAPP-AG, MPHI R01/12*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		No
Supporting Document	Application		No
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		No
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes

Form Schedule

Lead Form Number: MPAPP-DR R01/12

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 12/13/2011	MPAPP-DR R01/12	Application/ Enrollment Form	Application	Revised	Replaced Form #: MPAPP-DR R01/12 Previous Filing #: MPAPP-DR R7/101		MPAPP-DR (R01-12).pdf
Approved-Closed 12/13/2011	MPAPP-AG R01/12	Application/ Enrollment Form	Application	Revised	Replaced Form #: MPAPP-AG R01/12 Previous Filing #: MPAPP-AG R07/11		MPAPP-AG (R01-12).pdf
Approved-Closed 12/13/2011	MPPHI R01/12	Application/ Enrollment Form	Application	Initial			MPPHI R01-12.pdf

Medi-Pak Application

Before completing this application, please read the following instructions:

- This application is a legal document. If you are approved for coverage, it will become part of your contract. Therefore, it is very important that you provide **all** requested information and that it is accurate and legible.
- Some people have guaranteed rights into some Medicare supplement plans. If this applies to you, you are **not** required to complete the health questions (Sections 11, 12, or 13) or the Authorization to Disclose Protected Health Information (next page). If you do not have these guaranteed rights, please make sure you complete the health questions and the Authorization form.
- This application must be completed in dark blue or black ink. **No pencil please.**
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- **Do not use liquid paper, correction tape or "white out" to correct any mistakes you make on this application.**
- Any attached sheets must be signed and dated.
- Please ensure that you sign and date the application.
- Please do **not** send money with this application.
- **We strongly encourage you to make a photocopy of this completed application for your records.**

Policy Effective Dates:

The policy can become effective on either the 1st or the 15th of the month. Once your application is approved, we will attempt to contact you to find out what effective date you would like. Rules for effective dates are:

- You **cannot** have an effective date prior to your Medicare Part A and Part B effective dates.
- You **cannot** have an effective date prior to your termination from a Medicare Advantage plan.
- You **cannot** have an effective date prior to your application submit date.

What Is Open Enrollment?

State and federal laws guarantee that for a period of six months from the date you are both enrolled in Medicare Part B and are age 65 or older, you have a right to buy the Medicare supplement policy of your choice, regardless of any health problems you may have. Your open enrollment period begins with the first day of your birth month and continues for six months. If your birthday falls on the first day of the month, your Medicare coverage will begin the first day of the previous month, while you are age 64. Your open enrollment period will also begin at that time.

Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association
Form No. MPAPP-DR (R01/12)

good for you.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by the proposed insured.

Proposed Insured's Name Please Print	Signature	Date

Medi-Pak Application

For Arkansas Blue Cross Use Only
This application was received by:
☐ C ☐ NW ☐ NE ☐ WC ☐ SC
☐ SW ☐ SE ☐ Retail Store ☐ Customer Service
Date Stamp Here_____

1 WHO IS APPLYING

First Name	M.I.	Last Name	Suffix	Sex	Birth Date	Social Security No.

2 CONTACT INFORMATION

Primary Phone Number	Alternate Phone Number	Best Time to Call	E-Mail Address
( )	( )	AM PM	

3 RESIDENTIAL ADDRESS

Street Address	City	State	Zip	County
		AR		

4 MAILING ADDRESS (Complete only if different than residential address)

Street or P.O. Box	City	State	Zip

5 BILLING ADDRESS (Complete only if different than residential address)

Street or P.O. Box	City	State	Zip

6 MEDI-PAK PLAN (Choose One)

☐ **A** ☐ **F** ☐ **G** ☐ **N**

7 BILLING MODE (Check One Only)

How do you want to be billed? ☐ Monthly Bank Draft ☐ Monthly Invoice ($2.50 service charge) ☐ Quarterly Invoice

8 CURRENT BLUE CROSS COVERAGE

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

9 PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please fill in these blanks so they match your red, white and blue Medicare card. You must have both Medicare Hospital (Part A) and Medicare (Part B) coverage to apply for Medi-Pak.

Medicare Claim Number:_____

Hospital (Part A) Effective Date:_____ 01 _____
Month Day Year

Medical (Part B) Effective Date:_____ 01 _____
Month Day Year

MEDICARE HEALTH INSURANCE
SAMPLE ONLY
Name: Jane Doe
Medicare Claim Number: 123-45-6789 T Sex: F

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	09-01-2000
MEDICAL (Part B)	09-01-2000

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

☐Approved ☐ Denied Date_____ ICU_____	I.D.# GROUP #	EFFECTIVE DATE	PKG

HOME OFFICE ENDORSEMENTS:

 (Continued on page 2)

10 ELIGIBILITY QUESTIONS

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 mark Yes or No below with an "X" ---- To the best of your knowledge:

☐ **Yes** ☐ **No** 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?

c. If you answered **Yes** to 1b, what is the effective date?_____/_____/_____

☐ **Yes** ☐ **No** 2. 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 you answered **No** to 2, please go to 3a.

If you answered **Yes** to 2, please answer 2a and 2b.

☐ **Yes** ☐ **No** 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. Have you had coverage from a **Medicare Advantage** (HMO, PPO or PFFS) plan within the past 63 days?

If you answered **No** to 3a, please go to 4a.

If you answered **Yes** to 3a, please fill in your start and end dates below. If you are still covered under this plan, leave "END" date blank:

START_____/_____/_____ END_____/_____/_____

☐ **Yes** ☐ **No** b. If you are still covered under the **Medicare Advantage** 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 Advantage** plan?

☐ **Yes** ☐ **No** d. Did you drop a **Medicare supplement** policy to enroll in the **Medicare Advantage** plan?

☐ **Yes** ☐ **No** e. Did you move out of the service area of your Medicare Advantage plan?

☐ **Yes** ☐ **No** f. Did your Medicare Advantage plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guarantee issue into a Medigap policy?

☐ **Yes** ☐ **No** 4. a. Do you have another **Medicare supplement** policy in force?

If you answered **No** to 4a, please go to 5.

If you answered **Yes** to 4a, please answer 4b and 4c.

b. If so, with what company, and what plan do you have?_____

☐ **Yes** ☐ **No** c. If so, do you plan 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? (For example, an employer, union or individual plan)
If you answered **Yes** to 5, please answer 5a and 5b.

a. If so, with what company and what kind of policy? _____

b. What are your dates of coverage under the other policy? Please fill in your start and end dates below. If you are still covered under the other policy, leave "END" date blank: START_____/_____/_____ END_____/_____/_____

(Continued on page 3)

During your Medicare Supplement Open Enrollment (see cover page for "What is Open Enrollment?"), you are not required to complete the health questions (Sections 11, 12 or 13) or the Authorization To Disclose Protected Health Information (located after cover page). If you are in your Medicare Supplement Open Enrollment, please skip to Section 14.

If you are NOT in your Medicare Supplement Open Enrollment, please answer ALL of the following health questions. Acceptance or rejection of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage and our review of your answers to the medical questions. Applications cannot be processed unless all questions are answered.

11 MEDICAL QUESTIONNAIRE

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

In the last 10 years have you been told you had:
(Each section must have at least one box checked.)

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Convulsions, epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above**

B. RESPIRATORY

- ☐ Chronic obstructive pulmonary disease or asthma
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Ulcerative colitis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above**

D. EAR/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above**

 (Continued on page 4)

11 MEDICAL QUESTIONNAIRE (continued)

E. CIRCULATORY

- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer
- ☐ Hodgkin's disease
- ☐ Leukemia
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- ☐ **None of the above**

H. MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Fibromyalgia
- ☐ Lupus, systemic
- ☐ Any other disorder of the muscles, bones or joints
- ☐ **None of the above**

I. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ **None of the above**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ **None of the above**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above**

(Continued on page 5)

11 MEDICAL QUESTIONNAIRE (continued)

ADDITIONAL MEDICAL INFORMATION

Give full details to conditions checked for questions A thru K.

- Under "Condition/Illness and Type of Treatment" below, in addition to **condition/illness,** please provide the **type of treatment** provided or planned. For example:

  Surgery
  Hospitalization
  Emergency room visit
  Chiropractic treatments
  Nursing Home confinement
  Doctor visits
  Rehabilitation therapy — (e.g. speech, physical, occupational)

- Please ensure you include **all** the treatments that apply.

- **Please indicate the name(s) that would have been given at the time of the physician visit — e.g., a maiden name.**_____

Question Number(s)	Condition/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	
H	Condition/Illness: **Arthritis** Type of Treatment: **Doctor Visit**	**01** / **05** mo year	**07** / **09** mo year	**20**		**X**		**Dr. Jones 123 Main Street Anytown, AR 72221**
	Condition/Illness: Type of Treatment:	___/___ mo year	___/___ mo year					
	Condition/Illness: Type of Treatment:	___/___ mo year	___/___ mo year					
	Condition/Illness: Type of Treatment:	___/___ mo year	___/___ mo year					
	Condition/Illness: Type of Treatment:	___/___ mo year	___/___ mo year					
	Condition/Illness: Type of Treatment:	___/___ mo year	___/___ mo year					
	Condition/Illness: Type of Treatment:	___/___ mo year	___/___ mo year					

EXAMPLE

 (Continued on page 6)

11 MEDICAL QUESTIONNAIRE (continued)

1. Height_____ Weight_____

☐ **Yes** ☐ **No** 2. Are you Medicare Disabled?

If **Yes**, please indicate disability condition(s):

_____

_____

_____

☐ **Yes** ☐ **No** 3. Have you ever been declined or rated for the issuance of life, accident, health or long-term care insurance?

If **Yes**, please explain:

_____

_____

_____

☐ **Yes** ☐ **No** 4. Have you used any form of tobacco within the last 12 months?

If **Yes**, please indicate:

Type of tobacco _____

Amount_____

5. In the last 10 years have you:

☐ **Yes** ☐ **No** a. chronically or habitually used an alcoholic beverage(s) to the extent that your normal faculties are impaired; and/or been voluntarily or involuntarily committed to an alcohol abuse treatment facility; and/or been convicted of (2) or more offences related to the use of alcohol; and/or been found to have blood alcohol concentrations of 0.08% (federal presumptive level of intoxication for driving) or greater? If **Yes**, please explain:

_____

_____

☐ **Yes** ☐ **No** b. used any addictive or non-addictive drug or substance except as provided by a physician? If **Yes**, please explain:

_____

_____

☐ **Yes** ☐ **No** c. had unexplained or unintentional weight loss of 10 pounds or more? If **Yes**, please explain:

_____

_____

☐ **Yes** ☐ **No** d. required the assistance of any other individual for performances of any activities of daily living? If **Yes**, please check all that apply:

☐ Bathing ☐ Dressing ☐ Transferring
☐ Eating ☐ Toileting ☐ Continence

 (Continued on page 7)

12 PRIMARY PHYSICIAN INFORMATION

Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit

*Please write NO VISIT in this box if the applicant has never seen the physician.

13 PRESCRIPTION QUESTIONNAIRE

☐ **Yes** ☐ **No** Are you currently taking any prescription medication, or have you taken prescription medication in the **last 3 years?**

If you answered **Yes**, please provide full details below. A print out from the pharmacy is **not** acceptable.

Name of Drug	Dosage	Specific Condition or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Physician
				None	Partial	Full	
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				

14 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.

 (Continued on page 8)

14 IMPORTANT: PLEASE READ AND SIGN (continued)

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 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 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 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.

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 in 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 _____ _____

Sign Here (must be signed by proposed insured) Date

COMMENTS:

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

Proposed Insured's Information

First Name:_____ Last Name:_____

Address:_____
Street Apt. No.

_____
City State Zip

Bank Account Information

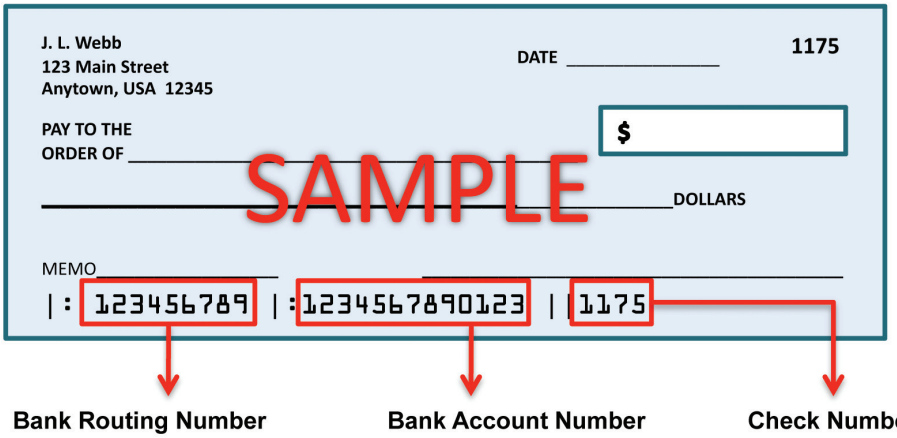
Bank Name:_____

Routing Number:_____

Name on Account: _____
(If different than the proposed insured)

Account Number:_____

Type of Account: ☐ Checking ☐ Savings



Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated above, to debit my Arkansas Blue Cross premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Signature

Signature_____ Date_____
Signature of Bank Account Holder

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

Arkansas
BlueCross BlueShield
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

Medi-Pak Application

Before completing this application, please read the following instructions:

- This application is a legal document. If you are approved for coverage, it will become part of your contract. Therefore, it is very important that you provide **all** requested information and that it is accurate and legible.
- Some people have guaranteed rights into some Medicare supplement plans. If this applies to you, you are **not** required to complete the health questions (Sections 11, 12, or 13) or the Authorization to Disclose Protected Health Information (next page). If you do not have these guaranteed rights, please make sure you complete the health questions and the Authorization form.
- This application must be completed in dark blue or black ink. **No pencil please.**
- If you make a mistake, please mark through the incorrect information, initial it and then provide the correct information.
- **Do not use liquid paper, correction tape or "white out" to correct any mistakes you make on this application.**
- Any attached sheets must be signed and dated.
- Please ensure that you sign and date the application.
- Please do **not** send money with this application.
- **We strongly encourage you to make a photocopy of this completed application for your records.**

Policy Effective Dates:

The policy can become effective on either the 1st or the 15th of the month. Once your application is approved, we will attempt to contact you to find out what effective date you would like. Rules for effective dates are:

- You **cannot** have an effective date prior to your Medicare Part A and Part B effective dates.
- You **cannot** have an effective date prior to your termination from a Medicare Advantage plan.
- You **cannot** have an effective date prior to your application submit date.

What Is Open Enrollment?

State and federal laws guarantee that for a period of six months from the date you are both enrolled in Medicare Part B and are age 65 or older, you have a right to buy the Medicare supplement policy of your choice, regardless of any health problems you may have. Your open enrollment period begins with the first day of your birth month and continues for six months. If your birthday falls on the first day of the month, your Medicare coverage will begin the first day of the previous month, while you are age 64. Your open enrollment period will also begin at that time.

Arkansas
BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

Form No. MPAPP-AG (R01/12)

good for you.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by the proposed insured.

Proposed Insured's Name Please Print	Signature	Date

Medi-Pak Application

1 WHO IS APPLYING

First Name	M.I.	Last Name	Suffix	Sex	Birth Date	Social Security No.

2 CONTACT INFORMATION

Primary Phone Number ( )	Alternate Phone Number ( )	Best Time to Call AM PM	E-Mail Address

3 RESIDENTIAL ADDRESS

Street Address | City | State AR | Zip | County

4 MAILING ADDRESS (Complete only if different than residential address)

Street or P.O. Box | City | State | Zip

5 BILLING ADDRESS (Complete only if different than residential address)

Street or P.O. Box | City | State | Zip

6 MEDI-PAK PLAN (Choose One)

☐ A ☐ F ☐ G ☐ N

7 BILLING MODE (Check One Only)

How do you want to be billed? ☐ Monthly Bank Draft ☐ Monthly Invoice ($2.50 service charge) ☐ Quarterly Invoice

8 CURRENT BLUE CROSS COVERAGE

Do you now have Blue Cross and Blue Shield Coverage? ☐ YES ☐ NO

Your Blue Cross I.D. No.:_____ City/State of Blue Cross Plan:_____

9 PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

Please fill in these blanks so they match your red, white and blue Medicare card. You must have both Medicare Hospital (Part A) and Medicare (Part B) coverage to apply for Medi-Pak.

Medicare Claim Number:_____

Hospital (Part A) Effective Date:_____ 01 _____
Month Day Year

Medical (Part B) Effective Date:_____ 01 _____
Month Day Year

MEDICARE HEALTH INSURANCE

SAMPLE ONLY

Name: Jane Doe

Medicare Claim Number: 123-45-6789 T Sex: F

Is Entitled To:	Effective Date:
HOSPITAL (Part A)	09-01-2000
MEDICAL (Part B)	09-01-2000

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

☐ Approved ☐ Denied Date_____ ICU_____	I.D.# GROUP #	EFFECTIVE DATE	PKG

HOME OFFICE ENDORSEMENTS:

 (Continued on page 2)

10 ELIGIBILITY QUESTIONS

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 mark Yes or No below with an "X" ---- To the best of your knowledge:

☐ **Yes** ☐ **No** 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?

c. If you answered Yes to 1b, what is the effective date?_____/_____/_____

☐ **Yes** ☐ **No** 2. 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 you answered **No** to 2, please go to 3a.
If you answered **Yes** to 2, please answer 2a and 2b.

☐ **Yes** ☐ **No** 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. Have you had coverage from a **Medicare Advantage** (HMO, PPO or PFFS) plan within the past 63 days?
If you answered **No** to 3a, please go to 4a.
If you answered **Yes** to 3a, please fill in your start and end dates below. If you are still covered under this plan, leave "END" date blank:
START_____/_____/_____ END_____/_____/_____

☐ **Yes** ☐ **No** b. If you are still covered under the **Medicare Advantage** 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 Advantage** plan?

☐ **Yes** ☐ **No** d. Did you drop a **Medicare supplement** policy to enroll in the **Medicare Advantage** plan?

☐ **Yes** ☐ **No** e. Did you move out of the service area of your Medicare Advantage plan?

☐ **Yes** ☐ **No** f. Did your Medicare Advantage plan terminate its contract with CMS, cease to provide all services, violate its contract or otherwise notify you that you were losing coverage and eligible for guarantee issue into a Medigap policy?

☐ **Yes** ☐ **No** 4. a. Do you have another **Medicare supplement** policy in force?
If you answered **No** to 4a, please go to 5.
If you answered **Yes** to 4a, please answer 4b and 4c.

b. If so, with what company, and what plan do you have?_____

☐ **Yes** ☐ **No** c. If so, do you plan 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? (For example, an employer, union or individual plan)
If you answered **Yes** to 5, please answer 5a and 5b.

a. If so, with what company and what kind of policy? _____

b. What are your dates of coverage under the other policy? Please fill in your start and end dates below. If you are still covered under the other policy, leave "END" date blank: START_____/_____/_____ END____/_____/_____

(Continued on page 3)

During your Medicare Supplement Open Enrollment (see cover page for "What is Open Enrollment?"), you are not required to complete the health questions (Sections 11, 12 or 13) or the Authorization To Disclose Protected Health Information (located after cover page). If you are in your Medicare Supplement Open Enrollment, please skip to Section 14.

If you are NOT in your Medicare Supplement Open Enrollment, please answer ALL of the following health questions. Acceptance or rejection of your application is subject to your enrollment in Medicare Hospital (Part A) and Medical (Part B) coverage and our review of your answers to the medical questions. Applications cannot be processed unless all questions are answered.

11 MEDICAL QUESTIONNAIRE

For each question checked below, give full details in the ADDITIONAL MEDICAL INFORMATION section which follows.

In the last 10 years have you been told you had:
(Each section must have at least one box checked.)

A. BRAIN OR NERVOUS SYSTEM DISORDERS

- ☐ Alzheimer's disease or senile dementia
- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Convulsions, epilepsy or seizures
- ☐ Meningitis
- ☐ Multiple sclerosis, muscular dystrophy or myasthenia gravis
- ☐ Neuritis
- ☐ Paralysis or palsy
- ☐ Parkinson's disease
- ☐ Polyneuritis
- ☐ Vertigo, fainting or dizziness
- ☐ Any other disorder of the brain or nervous system
- ☐ **None of the above**

B. RESPIRATORY

- ☐ Chronic obstructive pulmonary disease or asthma
- ☐ Obstructive or reactive airway disorder
- ☐ Sleep apnea
- ☐ Any other disorder of the lungs, bronchial tubes or respiratory system
- ☐ **None of the above**

C. DIGESTIVE

- ☐ Cirrhosis
- ☐ Crohn's disease
- ☐ Gastric bypass surgery or other weight loss procedure
- ☐ Gastric or duodenal ulcer
- ☐ Hepatitis
- ☐ Irritable bowel syndrome or gastric esophageal reflux disorder (GERD)
- ☐ Pancreatitis
- ☐ Pyloric stenosis
- ☐ Ulcerative colitis
- ☐ Any other disorder of stomach, intestines, liver, gallbladder or rectum
- ☐ **None of the above**

D. EAR/EYES/NOSE/THROAT

- ☐ Cataracts or glaucoma
- ☐ Meniere's disease
- ☐ Any other disorder of the eyes, ears, nose, throat or esophagus
- ☐ **None of the above**

 (Continued on page 4)

11 MEDICAL QUESTIONNAIRE (continued)

E. CIRCULATORY

- ☐ Angina, heart attack, myocardial infarction
- ☐ Arteriosclerosis, coronary artery disease, shunt placement and/or angioplasty
- ☐ Cerebrovascular accident (stroke), including transient ischemic attack (TIA)
- ☐ Chest pain, shortness of breath, heart murmur, palpitation of the heart, rheumatic fever
- ☐ Heart bypass surgery, pacemaker implant
- ☐ Heart surgery
- ☐ High blood pressure
- ☐ Hemophilia
- ☐ Any other disorder of the heart, blood, blood vessels or circulatory system
- ☐ **None of the above**

F. CANCERS, LYMPHATIC SYSTEM, BLOOD OR SKIN DISORDERS

- ☐ Anemia
- ☐ Cancer
- ☐ Hodgkin's disease
- ☐ Leukemia
- ☐ Melanoma, neoplasm or tumor
- ☐ Any other disorder of the lymphatic system
- ☐ Any other disorder of the skin
- ☐ **None of the above**

G. GLANDULAR DISORDERS

- ☐ Adrenal disorders
- ☐ Diabetes, abnormal glucose
- ☐ Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- ☐ **None of the above**

H. MUSCULOSKELETAL

- ☐ Arthritis
- ☐ Chronic fatigue
- ☐ Connective tissue disorder
- ☐ Fracture(s) or broken bone(s)
  Exposed bone ☐ Yes ☐ No
- ☐ Fibromyalgia
- ☐ Lupus, systemic
- ☐ Any other disorder of the muscles, bones or joints
- ☐ **None of the above**

I. KIDNEY, URINARY, REPRODUCTIVE

- ☐ Abnormal pap smear
- ☐ Bladder or renal stones
- ☐ Dialysis
- ☐ Nephritis
- ☐ Nephrotic syndrome, renal disease or failure
- ☐ Sexually transmitted disease
- ☐ Sugar, blood or protein in urine
- ☐ Any other disorder of the kidneys or urinary tract
- ☐ Any other disorder of the reproductive organs, including prostate, ovaries or breasts
- ☐ **None of the above**

J. MENTAL/EMOTIONAL OR SUBSTANCE ABUSE

- ☐ Anxiety, depression, emotional problems or nervous disorder
- ☐ Drug overdose
- ☐ Eating disorder
- ☐ Psychiatric treatment
- ☐ Any other mental, emotional disorder or situation
- ☐ **None of the above**

K. OTHER

- ☐ Current patient in a hospital or nursing home
- ☐ Sarcoidosis
- ☐ Any other implant(s), prosthetic device(s), internal fixation device(s) or retained hardware (i.e.: pins, wires, screws, shunts, stents)
- ☐ Acquired immune deficiency syndrome (AIDS), or AIDS-related complex or immune deficiency disorder or HIV
- ☐ Transplant recipient
- ☐ Any injury, deformity, incapacitation, disease or condition not listed elsewhere
- ☐ **None of the above**

(Continued on page 5)

11 MEDICAL QUESTIONNAIRE (continued)

ADDITIONAL MEDICAL INFORMATION

Give full details to conditions checked for questions A thru K.

- Under "Condition/Illness and Type of Treatment" below, in addition to **condition/illness,** please provide the **type of treatment** provided or planned. For example:

  Surgery
  Hospitalization
  Emergency room visit
  Chiropractic treatments
  Nursing Home confinement
  Doctor visits
  Rehabilitation therapy — (e.g. speech, physical, occupational)

- Please ensure you include **all** the treatments that apply.
- **Please indicate the name(s) that would have been given at the time of the physician visit — e.g., a maiden name.**_____

Question Number(s)	Condition/Illness **and** Type of Treatment	Date of First Visit	Date of Last Visit	Total # of Visits	Degree of Recovery			Complete Name and Address of Physician
					None	Partial	Full	
H	Condition/Illness: **Arthritis** Type of Treatment: **Doctor Visit**	**01** / **05** mo year	**07** / **09** mo year	**20**		**X**		**Dr. Jones 123 Main Street Anytown, AR 72221**
	Condition/Illness: Type of Treatment:	____/____ mo year	____/____ mo year					
	Condition/Illness: Type of Treatment:	____/____ mo year	____/____ mo year					
	Condition/Illness: Type of Treatment:	____/____ mo year	____/____ mo year					
	Condition/Illness: Type of Treatment:	____/____ mo year	____/____ mo year					
	Condition/Illness: Type of Treatment:	____/____ mo year	____/____ mo year					
	Condition/Illness: Type of Treatment:	____/____ mo year	____/____ mo year					

EXAMPLE

 (Continued on page 6)

11 MEDICAL QUESTIONNAIRE (continued)

1. Height_____ Weight_____

☐ **Yes** ☐ **No** 2. Are you Medicare Disabled?

If **Yes**, please indicate disability condition(s):

_____

_____

_____

☐ **Yes** ☐ **No** 3. Have you ever been declined or rated for the issuance of life, accident, health or long-term care insurance?

If **Yes**, please explain:

_____

_____

_____

☐ **Yes** ☐ **No** 4. Have you used any form of tobacco within the last 12 months?

If **Yes**, please indicate:

Type of tobacco _____

Amount_____

5. In the last 10 years have you:

☐ **Yes** ☐ **No** a. chronically or habitually used an alcoholic beverage(s) to the extent that your normal faculties are impaired; and/or been voluntarily or involuntarily committed to an alcohol abuse treatment facility; and/or been convicted of (2) or more offences related to the use of alcohol; and/or been found to have blood alcohol concentrations of 0.08% (federal presumptive level of intoxication for driving) or greater? If **Yes**, please explain:

_____

_____

☐ **Yes** ☐ **No** b. used any addictive or non-addictive drug or substance except as provided by a physician? If **Yes**, please explain:

_____

_____

☐ **Yes** ☐ **No** c. had unexplained or unintentional weight loss of 10 pounds or more? If **Yes**, please explain:

_____

_____

☐ **Yes** ☐ **No** d. required the assistance of any other individual for performances of any activities of daily living? If **Yes**, please check all that apply:

☐ Bathing ☐ Dressing ☐ Transferring
☐ Eating ☐ Toileting ☐ Continence

 (Continued on page 7)

12 PRIMARY PHYSICIAN INFORMATION

Complete Name and Address of Physician	Date of Last Visit*	Reason for Visit

*Please write NO VISIT in this box if the applicant has never seen the physician.

13 PRESCRIPTION QUESTIONNAIRE

☐ **Yes** ☐ **No** Are you currently taking any prescription medication, or have you taken prescription medication in the **last 3 years?**

If you answered **Yes**, please provide full details below. A print out from the pharmacy is **not** acceptable.

Name of Drug	Dosage	Specific Condition or Illness	Start Date/ Stop Date	Degree of Recovery			Complete Name and Address of Physician
				None	Partial	Full	
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				
			____/____ mo year ____/____ mo year				

14 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.

 (Continued on page 8)

14 IMPORTANT: PLEASE READ AND SIGN (continued)

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 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 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 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.

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 in 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 _____ _____

Sign Here (must be signed by proposed insured) Date

THIS SECTION TO BE COMPLETED BY SALES REPRESENTATIVE

List any other health insurance policies you have sold to this applicant.

(1) List policies sold which are still in force._____

(2) List policies sold in the past five (5) years which are no longer in force. _____

Sales Rep License #	Sales Representative's Name (Please Print) **X**	Telephone No.
Agency Federal Tax ID # (If applicable)	Sales Representative's Signature **X**	Date Signed

COMMENTS:

Pre-Authorized Bank Draft | Monthly Program Sign-up Form

Our monthly bank draft service makes premium payments easy and convenient for you. Completing this simple form helps assure your payments are made accurately and timely.

Depending on the health insurance plan you are applying for and the date your application is approved, we may be able to draft your first month's premium. If so, you will be notified prior to the draft. Once the bank draft is in effect, you will not receive a billing statement.

Complete the information below.

Proposed Insured's Information

First Name:_____ Last Name:_____

Address:_____

Street Apt. No.

_____

City State Zip

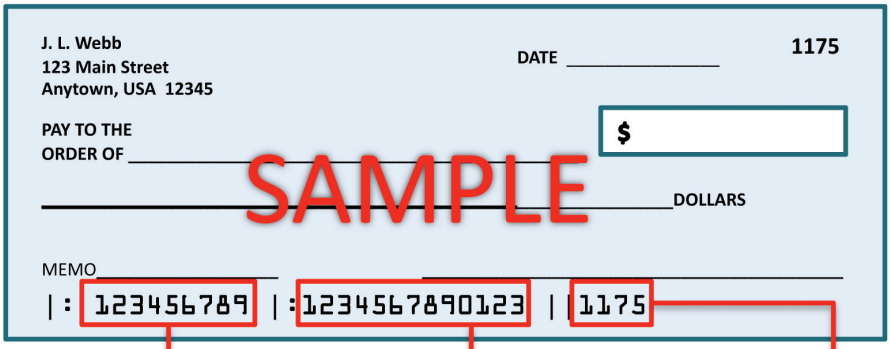
Bank Account Information

Bank Name:_____ Name on Account:_____

(If different than the proposed insured)

Routing Number:_____ Account Number:_____

Type of Account: ☐ Checking ☐ Savings



Important: Please Read Before Signing

I authorize Arkansas Blue Cross and Blue Shield and the BANK indicated above, to debit my Arkansas Blue Cross premium from my checking or savings account indicated above. This authority is to remain in full force and effect until my BANK has received written notification from me of the Pre-Authorized Bank Draft Program termination in such time and manner as to afford the BANK a reasonable opportunity to act on it, or until the BANK has sent me ten (10) days' written notice of the BANK's termination of this agreement.

I understand that by revoking the Pre-Authorized Bank Draft Program after I have agreed to it, I also will be terminating my Arkansas Blue Cross coverage, UNLESS Arkansas Blue Cross has received written notice from me of my desire to continue coverage at least twenty (20) days prior to the next Pre-Authorized Bank Draft Program withdrawal date.

I understand that an insufficient check fee will be assessed for any payment returned to Arkansas Blue Cross as a result of insufficient funds.

Signature

Signature_____ Date_____

Signature of Bank Account Holder

For Office Use Only (please do not write in this space)

ID NO.	EFFECTIVE DATE

Please keep for your records

Fair Credit Reporting Act Notice — Notice to Proposed Insured

In connection with your application for insurance, an investigative consumer report may be prepared. Information may be obtained through personal interviews with your family, friends, neighbors, business associates, financial sources, or others with whom you are acquainted. This inquiry includes information as to your character and general reputation. If an investigative consumer report is prepared in connection with your application, you may receive a copy of that report upon written request to Arkansas Blue Cross and Blue Shield. Your written request should be forwarded to Arkansas Blue Cross and Blue Shield, Individual Underwriting Division, P.O. Box 2181, Little Rock, Arkansas 72203-2181.

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Arkansas BlueCross BlueShield

An Independent Licensee of the Blue Cross and Blue Shield Association

IMPORTANT:

We cannot process your application without this completed form.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

As a condition of coverage and of my enrollment in the policy, I authorize any medical professional, medical care institution, pharmacy related service organization, pharmacy benefits manager, or other provider of health care services or supplies, as well as any individual, company or prior insurance carrier possessing relevant medical, health, treatment or payment information, to provide Arkansas Blue Cross and Blue Shield and its affiliates or agents information concerning services, supplies, benefits or payments provided or denied to me or to any family member listed in my application, including but not limited to any and all protected health information related to treatments where a restriction was requested for any health care item or service in relation to the health care provider having been paid in full out-of-pocket. I understand that information obtained as a result of this authorization will be used for the purpose of determining eligibility for coverage. This information may also be used by Arkansas Blue Cross and Blue Shield in investigating and adjudicating claims for benefits. I understand that in the course of its business operations, Arkansas Blue Cross and Blue Shield may disclose this information to others as required or permitted by law and as set out in the Arkansas Blue Cross and Blue Shield Notice of Privacy Practices. I understand that information re-disclosed may no longer be protected by federal privacy regulations. This authorization does not provide for the disclosure of psychotherapy notes as defined in 45 CFR §164.501. I understand that I may terminate this authorization by sending a written revocation to Arkansas Blue Cross and Blue Shield, 601 Gaines, Little Rock, AR 72203. However, if I revoke this authorization before I am enrolled in the policy(ies), my application for coverage will be denied. Unless I revoke this authorization, it shall be valid for 30 months from the date of my signature for information collected in connection with review of this application; it is valid for the duration of the coverage for information collected in connection with investigation of claims. Both the federal government and the State of Arkansas have enacted electronic signature laws, which allow the use of electronic signatures in all areas of commerce. See the Electronic Signatures in Global and National Commerce Act 15 USC §§ 7001 *et seq*., the Arkansas Electronic Records and Signatures Act A.C.A. §§25-31-101 *et seq.* and the Uniform Electronic Transaction Act, A.C.A. §§25-31-101 *et seq*. Electronic signatures are specifically authorized in the business of insurance. See 15 USC §§ 7001(i).

This authorization must be signed by each applicant age 18 or older.

_____	_____	____/____/_____
Proposed Insured's Name Please Print	Signature	Date