

SERFF Tracking Number: ARBB-127328357 State: Arkansas
 Filing Company: Arkansas Blue Cross and Blue Shield State Tracking Number: 49343
 Company Tracking Number: MPAPP_DR R7/11
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.001 Plan A 2010
 Standard Plans 2010
 Product Name: MediPak
 Project Name/Number: Applications/MPAPP_DR R7/11

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield

Product Name: MediPak SERFF Tr Num: ARBB-127328357 State: Arkansas
 TOI: MS08I Individual Medicare Supplement - Standard Plans 2010 SERFF Status: Closed-Approved- Closed State Tr Num: 49343
 Sub-TOI: MS08I.001 Plan A 2010 Co Tr Num: MPAPP_DR R7/11 State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Stephanie Fowler
 Authors: Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney Disposition Date: 08/01/2011
 Date Submitted: 07/19/2011 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Applications Status of Filing in Domicile: Pending
 Project Number: MPAPP_DR R7/11 Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: Arkansas is our state of Domicile.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 08/01/2011
 State Status Changed: 08/01/2011
 Deemer Date: Created By: Christi Kittler
 Submitted By: Christi Kittler Corresponding Filing Tracking Number: MPAPP_DR R7/11

Filing Description:

Attached please find forms MPAPP_DR R7/11 and MPAPP_AG R7/11 for your review and approval if indicated. These MediPak application forms have been modified to add our new bank draft form. The only change in bank draft form is to no longer ask for a voided check. Also attached is a Flesch Reading Ease score certification signed by an officer of the company as required by Arkansas Code Annotated §23-80-206(d).

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I certify that the submission meets the provisions of Arkansas Insurance Department Rule & Regulation 19. Please feel free to contact me at 378-2967 with any questions you may have.

Company and Contact

Filing Contact Information

Christi Kittler, Compliance Supervisor cmkittler@arkbluecross.com
 320 West Capitol, Ste 211 501-378-2967 [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? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: \$50.00/form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Arkansas Blue Cross and Blue Shield	\$100.00	07/19/2011	49902046

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	08/01/2011	08/01/2011

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Disposition

Disposition Date: 08/01/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	MediPak Application	Approved-Closed	Yes
Form	MediPak Application	Approved-Closed	Yes

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Form Schedule

Lead Form Number: MPAPP_DR R7/11

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/01/2011	MPAPP_D R R7/11	Application/	MediPak Application Enrollment Form	Revised	Replaced Form #: MPAPP-DR R9/10 Previous Filing #: MPAPP-DR R9/10	41.400	MApp_DR0711.pdf
Approved-Closed 08/01/2011	MAPP_A G R7/11	Application/	MediPak Application Enrollment Form	Revised	Replaced Form #: MPAPP-AG R9/10 Previous Filing #: MPAPP-AG R9/10	41.400	MApp_AG0711.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 (R07/11)

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 or organization, 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, 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. 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:			
<input type="checkbox"/> C	<input type="checkbox"/> NW	<input type="checkbox"/> NE	<input type="checkbox"/> WC
<input type="checkbox"/> SC	<input type="checkbox"/> SW	<input type="checkbox"/> SE	<input type="checkbox"/> 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 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: <u>Jane Doe</u>	Sex: <u>F</u>
Medicare Claim Number: <u>123-45-6789 T</u>	
Is Entitled To: HOSPITAL (Part A)	Effective Date: <u>09-01-2000</u>
MEDICAL (Part B)	<u>09-01-2000</u>

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

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	I.D.#	EFFECTIVE DATE	PKG
Date _____ ICU _____	GROUP #		

HOME OFFICE ENDORSEMENTS:

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 ____/____/____



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**

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**

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**

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**

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**

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**

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**

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**

G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes, abnormal glucose
- Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- 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**

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**

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

- 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					

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:

- | | | |
|----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Transferring |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Toileting | <input type="checkbox"/> Continence |

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				

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.

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 reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

In signing below, I represent that the statements and answers given 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: _____ Name on Account: _____

(If different than the proposed insured)

Routing Number: _____ Account Number: _____

Type of Account: Checking Savings

J. L. Webb
123 Main Street
Anytown, USA 12345

DATE _____ 1175

PAY TO THE ORDER OF _____ \$ _____

_____ DOLLARS

MEMO

| : 123456789 | : 1234567890123 | 1175

Bank Routing Number

Bank Account Number

Check Number

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.

Signature

Signature _____ Date _____

Signature of Bank 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 (R07/11)

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, 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, 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. 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
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3 RESIDENTIAL ADDRESS

Street Address	City	State AR	Zip	County
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4 MAILING ADDRESS (Complete only if different than residential address)

Street or P.O. Box	City	State	Zip
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5 BILLING ADDRESS (Complete only if different than residential address)

Street or P.O. Box	City	State	Zip
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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: <u>Jane Doe</u>	
Medicare Claim Number: <u>123-45-6789 T</u>	Sex: <u>F</u>
Is Entitled To: <u>HOSPITAL (Part A)</u>	Effective Date: <u>09-01-2000</u>
<u>MEDICAL (Part B)</u>	<u>09-01-2000</u>

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

<input type="checkbox"/> Approved <input type="checkbox"/> Denied	I.D.#	EFFECTIVE DATE	PKG
Date _____ ICU _____	GROUP #		

HOME OFFICE ENDORSEMENTS:

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 _____ / _____ / _____



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**

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**

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**

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**

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**

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**

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**

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**

G. GLANDULAR DISORDERS

- Adrenal disorders
- Diabetes, abnormal glucose
- Any other disorder of the pancreas, thyroid, pituitary, adrenal or other glands
- 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**

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**

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

- 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	<u>01 / 05</u> mo / year	<u>07 / 09</u> mo / year	20		X		Dr. Jones 123 Main Street Anytown, AR 72221
	Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
	Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
	Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
	Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
	Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
	Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					

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:

- | | | |
|----------------------------------|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Bathing | <input type="checkbox"/> Dressing | <input type="checkbox"/> Transferring |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Toileting | <input type="checkbox"/> Continence |

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.

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 reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.

5. If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

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

In signing below, I represent that the statements and answers given 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.

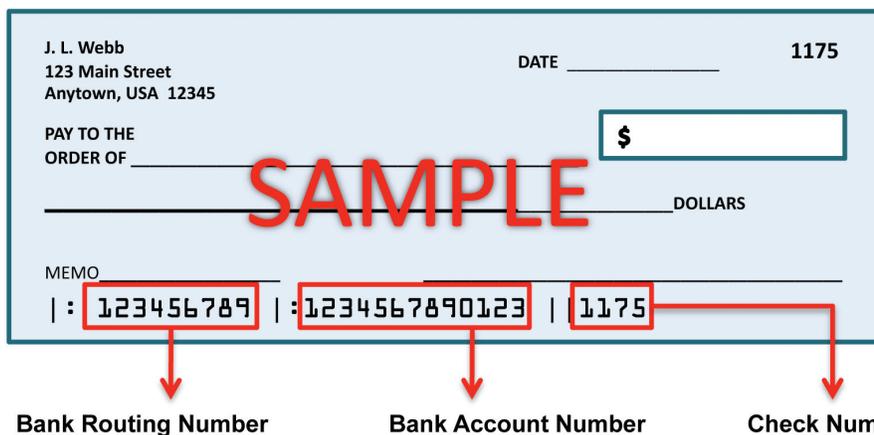
Complete the information below.

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.

Signature

Signature _____ Date _____
Signature of Bank 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**

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P.O. Box 2181, Little Rock, AR 72203-2181
www.ArkansasBlueCross.com

<i>SERFF Tracking Number:</i>	ARBB-127328357	<i>State:</i>	Arkansas
<i>Filing Company:</i>	Arkansas Blue Cross and Blue Shield	<i>State Tracking Number:</i>	49343
<i>Company Tracking Number:</i>	MPAPP_DR R7/11		
<i>TOI:</i>	MS08I Individual Medicare Supplement - Standard Plans 2010	<i>Sub-TOI:</i>	MS08I.001 Plan A 2010
<i>Product Name:</i>	MediPak		
<i>Project Name/Number:</i>	Applications/MPAPP_DR R7/11		

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved	08/01/2011
Comments:	Please see attached.		
Attachment:	Flesch Certification Form.pdf		
Satisfied - Item:	Application		
Comments:	Applications are attached under forms schedule.		
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not required for this filing.		
Comments:			
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Not required for this filing.		
Comments:			



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

RE: Arkansas Blue Cross and Blue Shield
Form No. MPAPP-AG (R07/11) and MPAPP-DR (R07/11)

**FLESCH READING EASE
CERTIFICATION**

This is to certify that the above referenced documents have achieved a Flesch Reading Ease Score average of 41.4 and comply with the requirements of A.C.A. §23-80-201 *et. seq.*, cited as the Life and Health Insurance Policy Language Simplification Act.

Name

Senior Vice President

Title

July 19, 2011

Date