

State: Arkansas **Filing Company:** Arkansas Blue Cross and Blue Shield
TOI/Sub-TOI: MS06 Medicare Supplement - Other/MS06.000 Medicare Supplement - Other
Product Name: 2013 Med Sup
Project Name/Number: Advertising Pieces/MP13-OOC,MPI 1457, MPI 1459, MPI 1464, MPI 1465, MPAPP-AG (R01/13), MPAPP_DR (R01/13)

Filing at a Glance

Company: Arkansas Blue Cross and Blue Shield
Product Name: 2013 Med Sup
State: Arkansas
TOI: MS06 Medicare Supplement - Other
Sub-TOI: MS06.000 Medicare Supplement - Other
Filing Type: Form/Advertisement
Date Submitted: 01/10/2013
SERFF Tr Num: ARBB-128843561
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: MP13-OOC

Implementation: On Approval
Date Requested:
Author(s): Christi Kittler, Yvonne McNaughton, Frank Sewall, Rita Thatcher, Evelyn Laney
Reviewer(s): Stephanie Fowler (primary)
Disposition Date: 01/15/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

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General Information

Project Name: Advertising Pieces Status of Filing in Domicile: Pending
 Project Number: MP13-OOC,MPI 1457, MPI 1459, MPI 1464, MPI 1465, MPAPP-AG (R01/13), MPAPP_DR (R01/13) Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments: Arkansas is state of domicile.
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Individual Market Type:
 Overall Rate Impact: Filing Status Changed: 01/15/2013
 State Status Changed: 01/15/2013
 Deemer Date: Created By: Evelyn Laney
 Submitted By: Evelyn Laney Corresponding Filing Tracking Number:

Filing Description:

Attached please find forms MP13-OCC, MPI 1457(Cover Letter), MPI 1459 DR Fulfillment OE, MPI 1464, MPI 1465, MPI 1480, MPI1481, MPI 1482(brochures), MPAPP-AG (R01/13) and MPAPP-DR (R01/13) for your review and approval. These are all advertising marketing materials to be used for Medicare Supplement Policies in 2013. These pieces are like ones we have filed in the past with the exception of 2013 Medicare rates. 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? Yes
 Fee Amount: \$500.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Arkansas Blue Cross and Blue Shield	\$500.00	01/10/2013	66437233

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Stephanie Fowler	01/15/2013	01/15/2013

SERFF Tracking #:

ARBB-128843561

State Tracking #:

Company Tracking #:

MP13-OOC

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Disposition

Disposition Date: 01/15/2013

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		Yes
Supporting Document	Outline of Coverage		Yes
Form	Outline of Coverage	Filed-Closed	Yes
Form	Cover Letter	Filed-Closed	Yes
Form	DR Fulfillment OE	Filed-Closed	Yes
Form	Brochure	Filed-Closed	Yes
Form	Brochure	Filed-Closed	Yes
Form	Brochure	Filed-Closed	Yes
Form	Brochure	Filed-Closed	Yes
Form	Brochure	Filed-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	application	Approved-Closed	Yes

SERFF Tracking #:

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MP13-OOC

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

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Form Schedule

Lead Form Number: MP13-OOC									
Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Filed-Closed 01/15/2013	Outline of Coverage	MP13-OOC	ADV	Revised	Previous Filing Number:	ARBB-127971058		mp13-00C.pdf
						Replaced Form Number:	MP12-00C		
2	Filed-Closed 01/15/2013	Cover Letter	MPI 1457	ADV	Revised	Previous Filing Number:	ARBB-127964068		2013 Med Sup FF Kit - DR Cover Letter.pdf
						Replaced Form Number:	MP_FF_LT_01_12_DR		
3	Filed-Closed 01/15/2013	DR Fulfillment OE	MPI 1459	ADV	Revised	Previous Filing Number:	ARBB-127873990		2013 Med Sup FF Kit - DR OSE.pdf
						Replaced Form Number:	Fulfillment OE 2012		
4	Filed-Closed 01/15/2013	Brochure	MPI 1480	ADV	Initial				Control Costs Banner Ads_160_1_7_13.pdf
5	Filed-Closed 01/15/2013	Brochure	MPI 1481	ADV	Initial				Control Costs Banner Ads_300_1_7_13.pdf
6	Filed-Closed 01/15/2013	Brochure	MPI 1482	ADV	Initial				Control Costs Banner Ads_780_1_7_13.pdf

State: Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

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Lead Form Number: MP13-OOC

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
						Previous Filing Number:	Replaced Form Number:		
7	Filed-Closed 01/15/2013	Brochure	MPI 1464	ADV	Revised	Previous Filing Number:	ARBB-127898154		2013 Med Sup FF Kit - AG Folder.pdf
						Replaced Form Number:	MP_FF_AG_2012		
8	Filed-Closed 01/15/2013	Brochure	MPI 1465	ADV	Revised	Previous Filing Number:	ARBB-127898154		2013 Med Sup FF Kit - DR Folder.pdf
						Replaced Form Number:	MP_FF_DR_2012		
9	Approved-Closed 01/15/2013	Application	MPAPP-AG (R01/13)	ADV	Revised	Previous Filing Number:	ARBB-127893340		MPAPP-AG 2013 Med Sup FF Kit - (R01-13).pdf
						Replaced Form Number:	MPAPP-AG (R01/12)		
10	Approved-Closed 01/15/2013	application	MPAPP-DR (R01/13)	ADV	Revised	Previous Filing Number:	ARBB-127893340		MPAPP-DR 2013 Med Sup FF Kit - (R01-13).pdf
						Replaced Form Number:	MPAPP-DR (R01/12)		

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate

SERFF Tracking #:

ARBB-128843561

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Company Tracking #:

MP13-OOC

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Arkansas

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POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages
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2013

**Outline of Medicare
Supplement Coverage**

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE — COVER PAGE: Arkansas Blue Cross and Blue Shield Offers Benefit Plans A, F, G and N.

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in Arkansas. Plans E, H, I and J are no longer available for sale. **BASIC BENEFITS: Hospitalization:** Part A coinsurance plus coverage for 365 additional days after Medicare benefits end. **Medical Expenses:** Part B coinsurance, (generally 20% of Medicare-approved expenses), or copayments for hospital outpatient services. Plans K, L and N require insureds to pay a portion of Part B coinsurance or copayments. **Blood:** First three pints of blood each year. **Hospice:** Part A coinsurance. †**INNOVATIVE BENEFIT:** Not part of standard benefit plan. **The SilverSneakers® Fitness Program is an overall health and wellness program.**

A	B	C	D	F	F*	G	K**	L**	M	N
Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance*		Basic, including 100% Part B coinsurance	Hospitalization and preventive care paid at 100%; other basic benefits paid at 50%	Hospitalization and preventive care paid at 100%; other basic benefits paid at 75%	Basic, including 100% Part B coinsurance	Basic, including 100% Part B coinsurance, except up to \$20 copayment for office visit, and up to \$50 copayment for ER			
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance		Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible	50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Part B Deductible		Part B Deductible						
				Part B Excess (100%)		Part B Excess (100%)				
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency			Foreign Travel Emergency	Foreign Travel Emergency
							***Out-of-pocket limit \$4,800; paid at 100% after limit reached	***Out-of-pocket limit \$2,400; paid at 100% after limit reached		
SilverSneakers†				SilverSneakers†		SilverSneakers†				SilverSneakers†

* Plan F also has an option called a high deductible plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year \$2,000 deductible. Benefits from high deductible plan F will not begin until out-of-pocket expenses exceed \$2,110. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible. **Plans K and L provide for different cost-sharing for items and services than Plans A-G. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance, and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "excess charges." You will be responsible for paying excess charges. ***The out-of-pocket annual limit will increase each year for inflation.

PREMIUM INFORMATION

We, Arkansas Blue Cross and Blue Shield, can only raise your premium if we raise the premium for all policies like yours in the same service area as yours.

DISCLOSURES

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY

If you find that you are not satisfied with your policy, you may return it to Arkansas Blue Cross and Blue Shield, 601 Gaines Street, Little Rock, Arkansas 72203. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE

This policy may not fully cover all of your medical costs.

Neither Arkansas Blue Cross and Blue Shield nor its agents are connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "Medicare and You" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information.

Review the application carefully before you sign it. Be certain that all information has been properly recorded.

SERVICES	MEDICARE PAYS	PLAN PAYS				YOU PAY			
		A	F	G	N	A	F	G	N
FOREIGN TRAVEL – NOT COVERED BY MEDICARE									
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA									
First \$250 each calendar year	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	All Costs	\$250	\$250	\$250
Remainder of Charges	\$-0-	\$-0-	80% to a lifetime maximum benefit of \$50,000	80% to a lifetime maximum benefit of \$50,000	80% to a lifetime maximum benefit of \$50,000	All Costs	20% and amounts over the \$50,000 lifetime max.	20% and amounts over the \$50,000 lifetime max.	20% and amounts over the \$50,000 lifetime max.
SILVERSNEAKERS* SilverSneakers Fitness Program or SilverSneakers Steps	\$-0-	All Costs	All Costs	All Costs	All Costs	No Cost	No Cost	No Cost	No Cost
Vision Care**	\$-0-	All Costs	All Costs	All Costs	All Costs	No Cost	No Cost	No Cost	No Cost

Service Area 1 Counties: Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Chicot, Clay, Cleveland, Columbia, Craighead, Crawford, Crittenden, Desha, Drew, Franklin, Fulton, Grant, Greene, Jefferson, Johnson, Lafayette, Lee, Lincoln, Logan, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Newton, Phillips, Poinsett, Polk, Pope, Prairie, Randolph, Scott, Searcy, Sebastian, St. Francis, Stone, Union, Washington, White, Woodruff, Yell

Service Area 2 Counties: Clark, Cleburne, Conway, Cross, Dallas, Faulkner, Garland, Hempstead, Hot Spring, Howard, Independence, Izard, Jackson, Lawrence, Little River, Lonoke, Nevada, Ouachita, Perry, Pike, Pulaski, Saline, Sevier, Sharp, Van Buren

*SilverSneakers® is a registered mark of Healthways, Inc. The SilverSneakers Fitness Program is provided by Healthways, Inc. Healthways, Inc., is an independent company that operates separately from Arkansas Blue Cross and Blue Shield.

** See Medi-Pak Vision Care Program brochure/certificate for benefit details. The benefits provided under this program are in addition to, and not instead of, your benefits under Medicare or the Medi-Pak Medicare supplement certificate.

Medi-Pak insurance plans are not connected with or endorsed by the U.S. government or the federal Medicare program.

Service Area 1 Premiums

Monthly	\$ 99.40	\$140.00	\$111.30	\$ 92.00
Quarterly	\$298.20	\$420.00	\$333.90	\$276.00

Service Area 2 Premiums

Monthly	\$114.10	\$157.60	\$125.00	\$102.80
Quarterly	\$342.30	\$472.80	\$375.00	\$308.40

Medicare (Part B) — Medical Services — Per Calendar Year

SERVICES	MEDICARE PAYS	PLAN PAYS				YOU PAY			
		A	F	G	N	A	F	G	N
MEDICAL EXPENSES — IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment									
First \$147 of Medicare-Approved Amounts	\$-0-	\$-0-	\$147 (Part B Deductible)	\$-0-	\$-0-	\$147 (Part B Deductible)	\$-0-	\$147 (Part B Deductible)	\$147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	Generally 80%	Generally 20%	Generally 20%	Generally 20%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	\$-0-	\$-0-	\$-0-	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-Approved Amounts)	\$-0-	\$-0-	100%	100%	\$-0-	All Costs	\$-0-	\$-0-	All Costs
BLOOD									
First three pints	\$-0-	All Costs	All Costs	All Costs	All Costs	\$-0-	\$-0-	\$-0-	\$-0-
Next \$147 of Medicare-Approved Amounts*	\$-0-	\$-0-	\$147 (Part B Deductible)	\$-0-	\$-0-	\$147 (Part B Deductible)	\$-0-	\$147 (Part B Deductible)	\$147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	20%	20%	20%	\$-0-	\$-0-	\$-0-	\$-0-
CLINICAL LABORATORY SERVICES — TESTS FOR DIAGNOSTIC SERVICES	100%	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-
HOME HEALTH CARE MEDICARE-APPROVED SERVICES — Medically necessary skilled care services and medical supplies	100%	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-
— Durable medical equipment — First \$147 of Medicare-Approved Amounts*	\$-0-	\$-0-	\$147 (Part B Deductible)	\$-0-	\$-0-	\$147 (Part B Deductible)	\$-0-	\$147 (Part B Deductible)	\$147 (Part B Deductible)
Remainder of Medicare-Approved Amounts	80%	20%	20%	20%	20%	\$-0-	\$-0-	\$-0-	\$-0-

*Once you have been billed \$147 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. Medicare benefits are subject to change. Please consult the latest *Guide to Health Insurance for People with Medicare*.

Plans A, F, G, N
Medicare (Part A) — Hospital Services — Per Benefit Period

SERVICES	MEDICARE PAYS	PLAN PAYS				YOU PAY			
		A	F	G	N	A	F	G	N
HOSPITALIZATION* Semi-private room and board, general nursing and miscellaneous services and supplies									
First 60 days	All but \$1,184/benefit period	\$-0-	\$1,184	\$1,184	\$1,184	\$1,184	\$-0-	\$-0-	\$-0-
61st through 90th day	All but \$296 a day	\$296/day	\$296/day	\$296/day	\$296/day	\$-0-	\$-0-	\$-0-	\$-0-
91st day and after:									
– While using 60 lifetime reserve days	All but \$592 a day	\$592/day	\$592/day	\$592/day	\$592/day	\$-0-	\$-0-	\$-0-	\$-0-
– Once lifetime reserve days are used: – Additional 365 days	\$-0-	100% of Medicare-Eligible Expenses	\$-0-**	\$-0-**	\$-0-**	\$-0-**			
– Beyond the Additional 365 days	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	All Costs	All Costs	All Costs	All Costs
SKILLED NURSING FACILITY CARE*									
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital.									
First 20 days	All approved amounts	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-
21st through 100th day	All but \$148.00 a day	\$-0-	Up to \$148.00 a day	Up to \$148.00 a day	Up to \$148.00 a day	Up to \$148.00 a day	\$-0-	\$-0-	\$-0-
101st day and after	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	All Costs	All Costs	All Costs	All Costs
BLOOD									
First three pints	\$-0-	3 Pints	3 Pints	3 Pints	3 Pints	\$-0-	\$-0-	\$-0-	\$-0-
Additional Amounts	100%	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-	\$-0-
HOSPICE CARE									
You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited copayment/coinsurance for outpatient drugs and inpatient respite care	Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance	Medicare copayment/coinsurance	\$-0-	\$-0-	\$-0-	\$-0-

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

** **NOTICE:** When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.



**Arkansas
BlueCross BlueShield**

An Independent Licensee of the Blue Cross and Blue Shield Association

P.O. Box 2181 • Little Rock, AR 72203

arkansasbluecross.com

good for
you.

Greetings!

Thank you for requesting information about our Medi-Pak supplement insurance plans. Please give us a call toll free at **1-800-392-2583** (TTY **1-800-370-5869**), 8 a.m. to 5 p.m., Monday – Friday, and we'll be happy to answer any questions you have. Or, stop by one of our 7 locations around the state.

Either way, rest assured you will be talking *only* to employees that have been trained and certified in all of our Medicare products — including our Medi-Pak supplement insurance plans.

When you're ready to enroll ...

We've made this process easy with 3 options. You can:

-  Call us toll free at **1-800-392-2583** (TTY **1-800-370-5869**), 8 a.m. to 5 p.m., Monday – Friday. (We can enroll you right over the phone!)
-  Enroll on our Web site at **arkansasbluecross.com/Medicare**
-  Complete the enclosed application and return it in the postage-paid envelope provided.

We look forward to helping you any way we can.

Best regards,

Brad Welshans
Individual Marketing Manager

To be eligible for Medi-Pak, you must be enrolled in Medicare Part A and Part B and reside in the state of Arkansas.

Medi-Pak Medicare supplement insurance plans are not connected with or endorsed by the U.S. government or the federal Medicare program. Hospital benefits must be provided by facilities participating with Medicare. Plans are guaranteed renewable, premium rates are subject to change upon thirty (30) days' written notice. Medi-Pak insurance has terms and conditions that may affect coverage. For costs and complete details of the coverage, contact Arkansas Blue Cross and Blue Shield.

Unless you apply for Medi-Pak coverage during a guarantee issue period mandated by federal and state law, you must answer health questions, be subjected to medical underwriting and may not be accepted for coverage.

SilverSneakers® is a registered mark of Healthways, Inc. The SilverSneakers Fitness Program is provided by Healthways, Inc. Healthways, Inc. is an independent company that operates separately from Arkansas Blue Cross and Blue Shield.

Since applications for Medi-Pak Medicare supplement insurance plans take time to process, we advise you to keep your current health coverage in effect until we notify you that your application has been approved.



**Arkansas
BlueCross BlueShield**
An Independent Licensee of the Blue Cross and Blue Shield Association
P.O. Box 2181 • Little Rock, AR 72203



**Here's the free information YOU REQUESTED
from Arkansas Blue Cross and Blue Shield.**

Medi-Pak Medicare supplement insurance



Medi-Pak
MPI 1459

good for
you.

DR Fulfillment OE 2013



**Control your
medical
costs
with a
Medicare
supplement
insurance
policy from**



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**Find out
more!**

Control your
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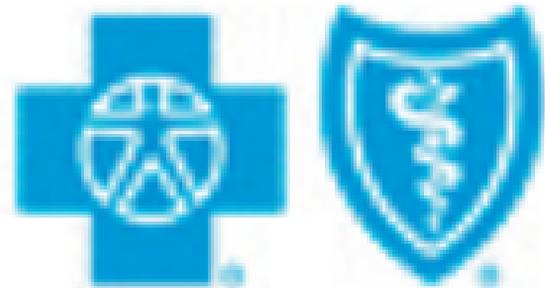
Find out more!

MPI 1481



MPI 1482

Control your **medical costs** with a Medicare supplement insurance policy from

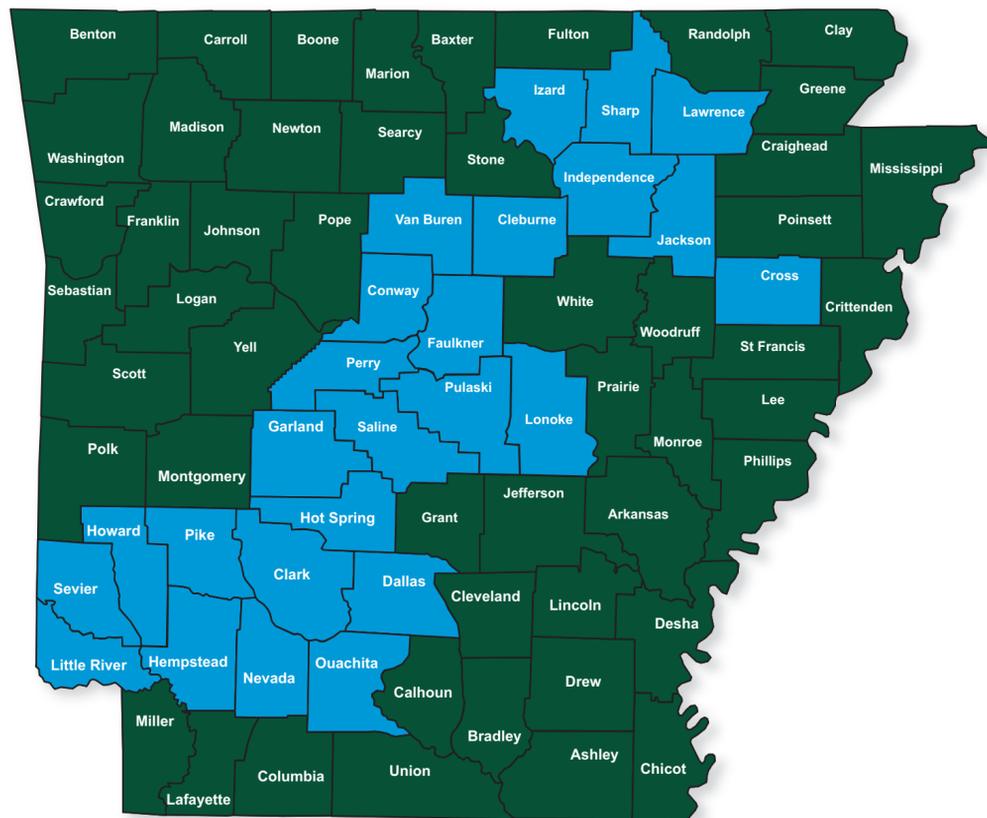


Arkansas
BlueCross BlueShield

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Find out
more!

Medi-Pak Medicare supplement Service Areas



- **Service Area 1** – Arkansas, Ashley, Baxter, Benton, Boone, Bradley, Calhoun, Carroll, Chicot, Clay, Cleveland, Columbia, Craighead, Crawford, Crittenden, Desha, Drew, Franklin, Fulton, Grant, Greene, Jefferson, Johnson, Lafayette, Lee, Lincoln, Logan, Madison, Marion, Miller, Mississippi, Monroe, Montgomery, Newton, Phillips, Poinsett, Polk, Pope, Prairie, Randolph, Scott, Searcy, Sebastian, St. Francis, Stone, Union, Washington, White, Woodruff and Yell.
- **Service Area 2** – Clark, Cleburne, Conway, Cross, Dallas, Faulkner, Garland, Hempstead, Hot Spring, Howard, Independence, Izard, Jackson, Lawrence, Little River, Lonoke, Nevada, Ouachita, Perry, Pike, Pulaski, Saline, Sevier, Sharp and Van Buren.

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arkansasbluecross.com/Medicare



2013 Medi-Pak Medicare supplement insurance policy

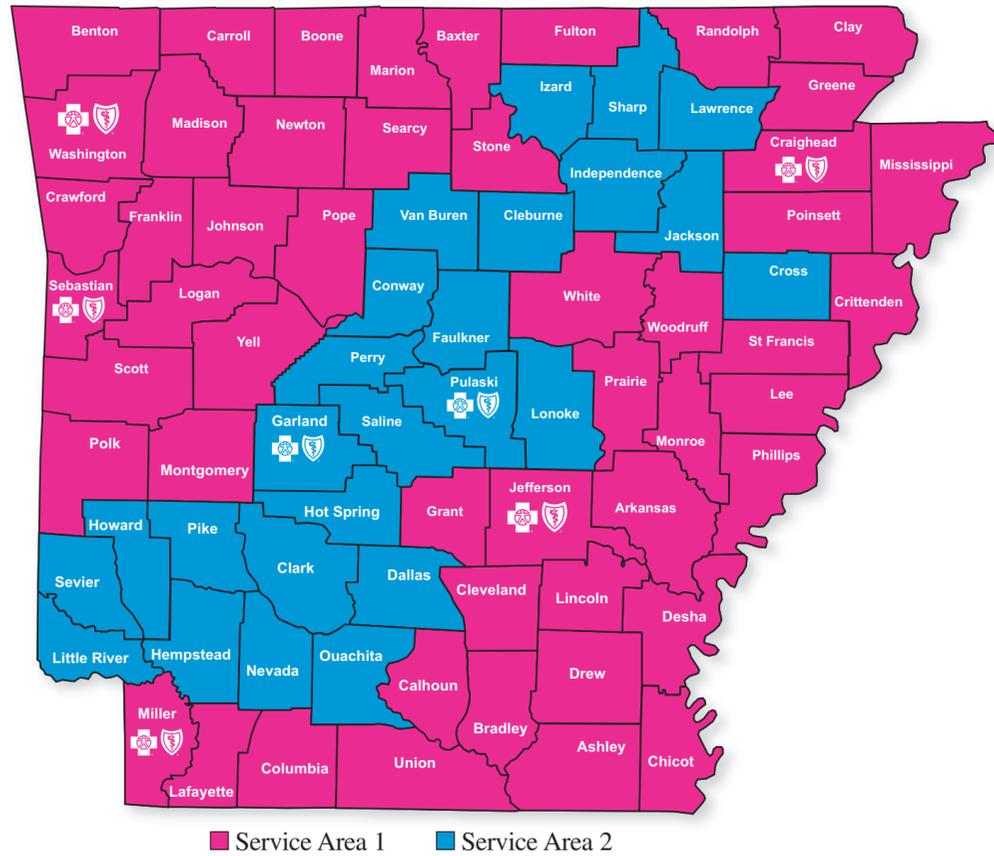
 **Arkansas BlueCross BlueShield**
 An Independent Licensee of the Blue Cross and Blue Shield Association

good for **you.**

MP_FF_AG_2013
 MPI 1464

AG

Medi-Pak Medicare supplement Service Areas



Sales Centers around Arkansas:

- 
Fayetteville
 516 E. Millsap Rd., Suite 103
 Phone: 1-888-847-1900
- 
Fort Smith
 3501 Old Greenwood Rd., Suite 5
 Phone: 1-800-299-4060
- 
Hot Springs
 1820 Central Ave., Suite F
 Phone: 1-800-588-5733
- 
Jonesboro
 707 E. Matthews Ave.
 Phone: 1-800-619-7690
- 
Little Rock
 ArkansasBlue — Shackleford Crossings
 2612 S. Shackleford Rd., Suite J
 Phone: 501-378-2222
- 
Pine Bluff
 We're moving in 2013, call us for our address.
 Phone: 1-800-330-3072
- 
Texarkana
 1710 Arkansas Blvd.
 Phone: 1-800-470-9621



2013 Medi-Pak Medicare supplement insurance policy



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MP_FF_DR_2013
MPI 1465

MP DR

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 (R01/13)

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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 72201. 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)																								
<input type="checkbox"/> A	<input type="checkbox"/> F	<input type="checkbox"/> G	<input type="checkbox"/> N																					
7 BILLING MODE (Check One Only)																								
How do you want to be billed?																								
<input type="checkbox"/> Monthly Bank Draft	<input type="checkbox"/> Monthly Invoice (\$2.50 service charge)	<input type="checkbox"/> Quarterly Invoice																						
8 CURRENT BLUE CROSS COVERAGE																								
Do you now have Blue Cross and Blue Shield Coverage? <input type="checkbox"/> YES <input type="checkbox"/> 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.					<table border="1" style="width:100%; border-collapse: collapse;"> <tr style="background-color: #cccccc;"> <td style="text-align: center;">MEDICARE</td> <td style="text-align: center;"></td> <td style="text-align: center;">HEALTH INSURANCE</td> </tr> <tr> <td colspan="3" style="text-align: center;">SAMPLE ONLY</td> </tr> <tr> <td colspan="3">Name: <u>Jane Doe</u></td> </tr> <tr> <td>Medicare Claim Number: 123-45-6789 T</td> <td colspan="2">Sex: <u>F</u></td> </tr> <tr> <td>Is Entitled To: HOSPITAL (Part A)</td> <td colspan="2">Effective Date: <u>09-01-2000</u></td> </tr> <tr> <td>MEDICAL (Part B)</td> <td colspan="2"><u>09-01-2000</u></td> </tr> </table>		MEDICARE		HEALTH INSURANCE	SAMPLE ONLY			Name: <u>Jane Doe</u>			Medicare Claim Number: 123-45-6789 T	Sex: <u>F</u>		Is Entitled To: HOSPITAL (Part A)	Effective Date: <u>09-01-2000</u>		MEDICAL (Part B)	<u>09-01-2000</u>	
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Hospital (Part A) Effective Date: _____ 01 _____ Month Day Year																								
Medical (Part B) Effective Date: _____ 01 _____ Month Day Year																								
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 "Specific 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	Specific 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
	Specific Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
	Specific Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					
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	Specific Condition/Illness: Type of Treatment:	<u> / </u> mo / year	<u> / </u> mo / year					

11 MEDICAL QUESTIONNAIRE (continued)

Height/Weight 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.

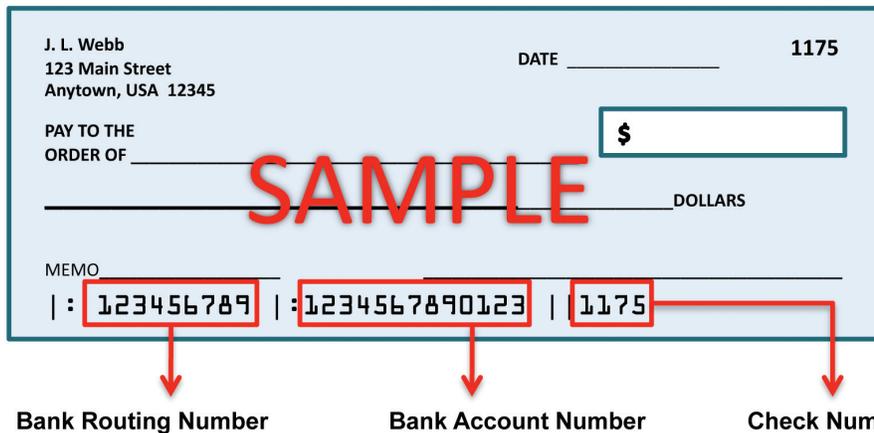
Complete the information below.

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.

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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P.O. Box 2181, Little Rock, AR 72203-2181

www.ArkansasBlueCross.com

Medi-Pak Application

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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 72201. 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"/> Retail Store
Date Stamp Here _____			<input type="checkbox"/> Customer Service

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:

<input type="checkbox"/> Yes	<input type="checkbox"/> No	1. a. Did you turn age 65 in the last 6 months?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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? ____/____/____
<input type="checkbox"/> Yes	<input type="checkbox"/> 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.
<input type="checkbox"/> Yes	<input type="checkbox"/> No	a. Will Medicaid pay your premiums for this Medicare supplement policy?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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 ____/____/____
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	c. Was this your first time in this type of Medicare Advantage plan?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	d. Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan?
<input type="checkbox"/> Yes	<input type="checkbox"/> No	e. Did you move out of the service area of your Medicare Advantage plan?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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? _____
<input type="checkbox"/> Yes	<input type="checkbox"/> No	c. If so, do you plan to replace your current Medicare supplement policy with this policy?
<input type="checkbox"/> Yes	<input type="checkbox"/> 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 "Specific 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)	Specific 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	Specific 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
	Specific Condition/Illness: Type of Treatment:	 mo / year	 mo / year					
	Specific Condition/Illness: Type of Treatment:	 mo / year	 mo / year					
	Specific Condition/Illness: Type of Treatment:	 mo / year	 mo / year					
	Specific Condition/Illness: Type of Treatment:	 mo / year	 mo / year					
	Specific Condition/Illness: Type of Treatment:	 mo / year	 mo / year					
	Specific Condition/Illness: Type of Treatment:	 mo / year	 mo / year					

11 MEDICAL QUESTIONNAIRE (continued)

Height/Weight 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.

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

SERFF Tracking #:

ARBB-128843561

State Tracking #:

Company Tracking #:

MP13-OOC

State:

Arkansas

Filing Company:

Arkansas Blue Cross and Blue Shield

TOI/Sub-TOI:

MS06 Medicare Supplement - Other/MS06.000 Medicare Supplement - Other

Product Name:

2013 Med Sup

Project Name/Number:

Advertising Pieces/MP13-OOC,MPI 1457, MPI 1459, MPI 1464, MPI 1465, MPAPP-AG (R01/13), MPAPP_DR (R01/13)

Supporting Document Schedules

		Item Status:	Status Date:
Bypassed - Item:	Flesch Certification		
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Application		
Bypass Reason:	Already attached.		
		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification		
Bypass Reason:	Not required.		
		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage		
Bypass Reason:	Already attached.		