INSURERS OF IDAHO
HEALTH INSURANCE SPECIALIST

Medicare Supplement Application Coversheet

Please note Medicare Supplement Applications **must be accompanied with a payment in order to be processed; please call with questions or concerns.

Dear Applicant,

Thank you for choosing INSURERS OF IDAHO. We look forward to assisting you.

- ☐ **I would like confirmation that you have received my application.**
  - ☐ Please email me.
  - ☐ Please call me.

- ☐ **I would like to be updated periodically on the applications status.**
  - ☐ Please update me by email.
  - ☐ Please call me with updates.

- ☐ **Yes, please submit my application to multiple carriers.**

Your Contact Information

Email:

Phone number:

Mail completed applications to:

Insurers of Idaho/ Applications
3006 E Goldstone Dr. Ste 207
Meridian, ID 83642

Classic Blue℠

2007 Medicare Supplement Health Insurance

You think about finding the health insurance plan that's right for you.

We think about providing you with affordable medicare supplement coverage.

Policy Form No. 4-132 (8-03)
Policy Form No. 4-215 (8-03)
Policy Form No. 4-155 (8-03)
Policy Form No. 4-131 (10-03)
Policy Form No. 4-217 (10-03)
Policy Form No. 4-151 (10-03)
Policy Form No. 3-604 (01-06)
Policy Form No. 4-605 (01-06)

Form No. 3-200 (03-07)

CLASSIC BLUE

2007 Medicare Supplement

HEALTH INSURANCE

BLUE CROSS OF IDAHO'S CLASSIC BLUE MEDICARE

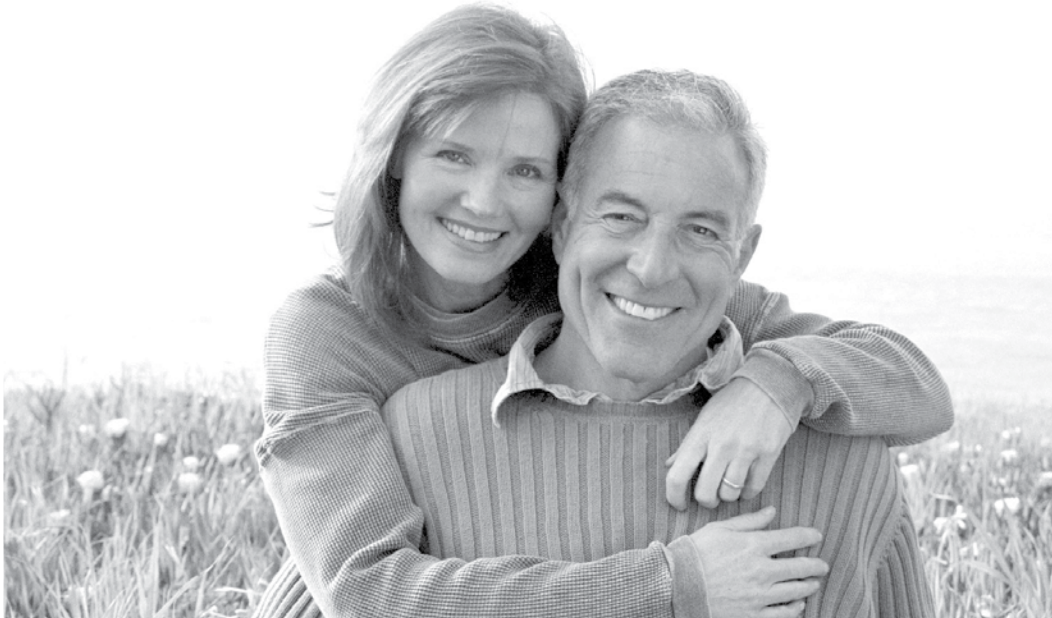
SUPPLEMENT PLANS ARE AN AFFORDABLE CHOICE FOR MEDICARE SUPPLEMENT COVERAGE.

BLUE CROSS OF IDAHO MEDICARE SUPPLEMENTS:

- Automatically pay higher benefits when Medicare deductible and coinsurance amounts increase
- Pay benefits immediately without any waiting period for preexisting conditions
- Cannot be cancelled because of age, changes in health or use of benefits
- Offer the same coverage for services anywhere in the U.S.

Classic Blue

2007 Medicare Supplement
Health Insurance



Blue Cross of Idaho Medicare Supplement Plans

If you have a Medicare health plan, you probably know it is not designed to pay for everything.

Blue Cross of Idaho offers low-cost Classic Blue Medicare supplement plans to help fill in the gaps in your Medicare coverage.

If you have enrolled in Medicare Part A and Part B, you are eligible to enroll in a Classic Blue Medicare supplement plan.

Classic Blue Medicare supplement plans from Blue Cross of Idaho help pay

THE ELIGIBLE EXPENSES NOT COVERED BY MEDICARE.

Why Classic Blue?

Medicare Part A provides hospital insurance and helps pay for inpatient care. Part B is medical insurance that helps pay for doctors' services and outpatient care. While Medicare Part A and Part B pay for many health care services you need, there are many costs that are not covered. You must pay some coinsurance, copayments and deductibles. These costs are sometimes called gaps in Medicare coverage and a Classic Blue Medicare supplement plan will help you cover the gaps.

Which plan is right for you?

Blue Cross of Idaho offers Medicare supplement Plans A, C, F and J. Plan A is the most basic and least expensive; Plans C and F pay your Part A and Part B deductibles and cover a few other services. Plan J provides the most coverage and is priced below Plans C and F, giving you the greatest value.

For more information call (800) 365-2345 or contact your local Blue Cross of Idaho district office at the numbers listed below.

Boise Office
3000 East Pine Avenue
Meridian, Idaho 83642-5995
(208) 387-6683

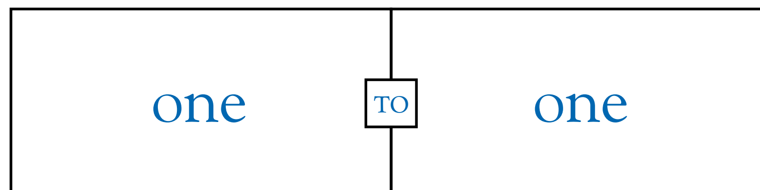
Coeur d'Alene Office
1900 Northwest Boulevard,
Suite 109
Coeur d'Alene, Idaho 83814
(208) 666-1495

Idaho Falls Office
2116 East 25th Street
Idaho Falls, Idaho 83403
(208) 522-8813

Lewiston Office
1010 17th Street
Lewiston, Idaho 83501
(208) 746-0531

Pocatello Office
275 South 5th Avenue,
Suite 150
Pocatello, Idaho 83206
(208) 232-6206

Twin Falls Office
1431 North Fillmore Street,
Suite 200
Twin Falls, Idaho 83303
(208) 733-7258



Outline of Medicare Supplement Coverage (Benefit Plans A, C, F and J)

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must offer Plan A. Some plans may not be available in Idaho.

Basic Benefits included in all plans

Hospitalization:	Medical Expenses:	Blood:
Part A coinsurance plus coverage for 365 additional days after Medicare benefits end	Part B coinsurance (20% of Medicare approved expenses)	First 3 pints of blood each year

Classic Blue Plan A	B	Classic Blue Plan C	D	E	Classic Blue Plan F	G	H	I	Classic Blue Plan J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		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	Foreign Travel Emergency	Foreign Travel Emergency
			At-home Recovery			At-home Recovery		At-home Recovery	At-home Recovery
				Preventive Care					Preventive Care

Payment Method

When you choose a Blue Cross of Idaho Medicare Supplement plan you get to choose the payment method and schedule that works best for you.

Monthly Automatic Bank Withdrawal

Blue Cross of Idaho accepts payment through electronic funds transfer from most financial institutions. To set up automatic payments from your bank account, complete the Authorization Agreement for Preauthorized Payments section of the enclosed Medicare Supplement Application or call your local Blue Cross of Idaho district office.

Monthly Direct Coupon

You will receive a bill that will be due on the first of each month. A $2.00 monthly billing fee will be charged when you choose this payment method.

Age at issue	Classic Blue Plan A		Classic Blue Plan C		Classic Blue Plan F		Classic Blue Plan J	
	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
Under 65	$112.14	$129.02	$205.27	$236.20	$210.22	$241.94	$187.10	$215.33
65	$77.95	$89.76	$142.73	$164.44	$146.67	$168.60	$130.54	$150.06
66	$79.52	$91.56	$145.88	$167.92	$149.71	$172.32	$133.24	$153.36
67	$81.32	$93.59	$149.03	$171.52	$152.86	$175.91	$136.05	$156.57
68	$83.01	$95.60	$152.07	$175.01	$156.12	$179.51	$138.95	$159.77
69	$84.59	$97.41	$155.10	$178.61	$159.15	$183.34	$141.65	$163.17
70	$86.27	$99.32	$158.13	$182.10	$162.42	$186.94	$144.55	$166.38
71	$87.85	$101.12	$161.18	$185.36	$165.34	$190.42	$147.16	$169.48
72	$89.65	$103.15	$164.33	$188.96	$168.60	$194.14	$150.06	$172.79
73	$91.22	$105.06	$167.25	$192.44	$171.75	$197.62	$152.86	$175.89
74	$92.80	$106.86	$170.29	$195.93	$174.68	$201.11	$155.47	$179.00
75	$94.60	$108.88	$173.21	$199.31	$177.71	$204.59	$158.17	$182.09
76	$96.28	$110.80	$176.47	$203.02	$181.09	$208.42	$161.17	$185.50
77	$98.08	$112.82	$179.51	$206.50	$184.13	$212.02	$163.88	$188.70
78	$99.88	$114.96	$182.88	$210.55	$187.72	$215.96	$167.08	$192.21
79	$101.68	$117.09	$186.15	$214.26	$191.10	$219.78	$170.08	$195.61
80	$103.37	$119.01	$189.63	$218.20	$194.47	$223.72	$173.09	$199.11
81	$105.28	$121.26	$193.12	$222.14	$197.96	$227.77	$176.19	$202.72
82	$107.42	$123.51	$196.72	$226.41	$201.67	$232.15	$179.49	$206.62
83	$109.33	$125.87	$200.43	$230.68	$205.38	$236.31	$182.80	$210.33
84	$111.36	$128.12	$204.03	$234.85	$209.21	$240.70	$186.20	$214.23
85 plus	$112.14	$129.02	$205.27	$236.20	$210.22	$241.94	$187.10	$215.33
Dental Option	$14.90 per person, per month							

Per person, per month, effective January 1, 2007

Medicare (Part A) Hospital Services – Per Benefit Period

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

Services	Medicare	Classic Blue Plan A	Classic Blue Plan C	Classic Blue Plan F	Classic Blue Plan J
Hospitalization *Semiprivate room and board, general nursing and miscellaneous services and supplies*					
First 60 days	Covers all but $992	Covers $0	Covers $992 (your Part A deductible)	Covers $992 (your Part A deductible)	Covers $992 (your Part A deductible)
Days 61 through 90	Covers all but $248 a day	Covers up to $248 a day	Covers up to $248 a day	Covers up to $248 a day	Covers up to $248 a day
Days 91 and after, while using 60 lifetime reserve days	Covers all but $496 a day	Covers up to $496 a day	Covers up to $496 a day	Covers up to $496 a day	Covers up to $496 a day
After lifetime reserve days are used, additional 365 days	Covers $0	Pays 100% of Medicare eligible charges	Pays 100% of Medicare eligible charges	Pays 100% of Medicare eligible charges	Pays 100% of Medicare eligible charges
Beyond the additional 365 days	Covers $0	Covers $0	Covers $0	Covers $0	Covers $0
Skilled Nursing Facility Care *You must meet Medicare's requirements, including having been in the hospital for at least three days and entered a Medicare approved facility within 30 days after leaving the hospital*					
First 20 days	Covers all approved amounts	Covers $0	Covers $0	Covers $0	Covers $0
Days 21 through 100	Covers all but $124 a day	Covers $0	Covers up to $124 a day	Covers up to $124 a day	Covers up to $124 a day
Day 101 and after	Covers $0	Covers $0	Covers $0	Covers $0	Covers $0
Blood					
First 3 pints	Covers $0	Covers 3 pints	Covers 3 pints	Covers 3 pints	Covers 3 pints
Additional amounts	Covers 80%	Covers 20% of approved charges	Covers 20% of approved charges	Covers 20% of approved charges	Covers 20% of approved charges
Hospice Care *Available as long as your doctor certifies that you are terminally ill and you elect to receive these services*					
	Covers all but limited coinsurance for outpatient drugs and inpatient respite care	Covers $0	Covers $0	Covers $0	Covers $0

Medicare (Part B) Hospital Services – Per Calendar Year

Once you have been billed $131 of Medicare approved amounts for covered services, noted below with an asterisk (*), your Part B deductible will have been met for the calendar year.

Services	Medicare	Classic Blue Plan A	Classic Blue Plan C	Classic Blue Plan F	Classic Blue Plan J
Medical Expenses					
Inpatient 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, outpatient facility charges					
First $131 of Medicare approved amounts*	Covers $0	Covers $0	Covers $131 (your Part B deductible)	Covers $131 (your Part B deductible)	Covers $131 (your Part B deductible)
Remainder of Medicare approved amounts*	Covers 80%	Covers 20%	Covers 20%	Covers 20%	Covers 20%
Part B excess charges (above Medicare approved amounts)	Covers $0	Covers $0	Covers $0	Covers 100% of Medicare Part B excess charges up to a limiting charge as determined by Medicare	Covers 100% of Medicare Part B excess charges up to a limiting charge as determined by Medicare
Blood					
First 3 pints	Covers $0	Covers all costs	Covers all costs	Covers all costs	Covers all costs
Next $131 of Medicare approved amounts*	Covers $0	Covers $0	Covers $131 (your Part B deductible)	Covers $131 (your Part B deductible)	Covers $131 (your Part B deductible)
Remainder of Medicare approved amounts*	Covers 80%	Covers 20%	Covers 20%	Covers 20%	Covers 20%
Home Health Care					
Medicare approved services					
Medically necessary skilled care and services and medical supplies	Covers 100%	Covers $0	Covers $0	Covers $0	Covers $0
Durable Medical Equipment					
First $131 of Medicare approved amounts*	Covers $0	Covers $0	Covers $131 (your Part B deductible)	Covers $131 (your Part B deductible)	Covers $131 (your Part B deductible)
Remainder of Medicare approved amounts	Covers 80%	Covers 20%	Covers 20%	Covers 20%	Covers 20%

Additional Services

Services	Medicare	Classic Blue Plan A	Classic Blue Plan C	Classic Blue Plan F	Classic Blue Plan J
***Foreign Travel Emergency** Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA* **not covered by Medicare*					
First $250 each calendar year*	Covers $0	Covers $0	Covers $0	Covers $0	Covers $0
Remainder of charges*	Covers $0	Covers $0	Covers 80% to a lifetime maximum benefit of $50,000	Covers 80% to a lifetime maximum benefit of $50,000	Covers 80% to a lifetime maximum benefit of $50,000
Days 91 and after, while using 60 lifetime reserve days (covered under Medicare inpatient coverage)	Covers all but $496	Covers all but $496	Covers all but $496	Covers all but $496	Covers all but $496
After lifetime reserve days are used, additional 365 days*	Covers $0	Covers 100% of Medicare eligible charges	Covers 100% of Medicare eligible charges	Covers 100% of Medicare eligible charges	Covers 100% of Medicare eligible charges
Beyond the additional 365 days*	Covers $0	Covers $0	Covers $0	Covers $0	Covers $0
At-home Recovery					
	Covers all approved amounts	Covers $0	Covers $0	Covers $0	Covers 8 additional weeks of at-home help after skilled care is no longer needed up to $40 each visit and $1,600 each year
Preventive Care					
	Covers $0	Covers $0	Covers $0	Covers $0	Covers $120 per year
Vision					
	Covers $0	Covers $0	Covers $0	Cover 100% after $10 copayment on exam only at contracting providers, $45 toward exam and materials at non-contracting providers	Cover 100% after $10 copayment on exam only at contracting providers, $45 toward exam and materials at non-contracting providers

Classic Blue℠ Dental

Blue Cross of Idaho offers an optional dental plan that works alongside your Medicare supplement health coverage.

Benefits of Classic Blue Dental

- No deductible when you receive services from a dentist who is part of Blue Cross of Idaho's Preferred Provider Organization (PPO) network.
- No annual maximum.
- Oral exam preventive, cleaning and x-ray every 6 months with no charge to you when you see a contracting dentist.
- A full mouth x-ray once every 5 years with no cost to you when you see a contracting dentist.
- Chair-side denture reline procedure once every 24 months with no cost to you when you see a contracting dentist.

Dental Services	In-network	Out-of-network
Deductible	No deductible	You pay $50 per calendar year
Annual Maximum	No annual maximum	No annual maximum
Oral Exams – 1 visit every 6 months	You pay nothing when you visit a network provider	You pay 50% of the allowed amount after meeting your deductible
Cleanings – (basic) 1 visit every 6 months (preventive maintenance periodontics not covered)		
Dental X-rays – (bitewings) 1 visit every 6 months		
Full Mouth X-ray – 1 visit every 5 years		
Denture Reline Procedures – (chairside) Once every 24 months of coverage		

General Exclusions and Limitations

No benefits are available for services that are:

- Periodontal maintenance or periodontics not covered;
- Not specifically included in the list of Covered Services in your policy;
- Considered to be not medically necessary or investigational in nature;
- Rendered prior to your effective date of coverage; or
- Not prescribed by a dental care provider.

Termination of Coverage

If an enrollee terminates his or her enrollment in Classic Blue Dental, the enrollee may not apply for the Classic Blue Dental coverage for 24 months following the date of termination.

Read your Policy Carefully

This brochure describes the general features of the Classic Blue Dental option; it is not a contract. Policy #4-131-10/03, Policy #4-151-10/03, Policy 3-204-01/07 or Policy #4-217-10/03 are the actual contracts. All the provisions of the Policy apply. The benefits of the Policy are governed by the laws of the state of Idaho.

Premium Information

Blue Cross of Idaho can raise your premium only if we raise the premium for all individuals within your Blue Cross of Idaho Medicare supplement benefit plan.

Exclusions

Except as outlined, medical services not considered eligible under the Medicare program are also excluded from coverage with your Blue Cross of Idaho Medicare supplement policy.

Disclosures

Use this brochure to compare benefits and premiums among policies.

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. Blue Cross of Idaho 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.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to Blue Cross of Idaho at P.O. Box 7408 Boise ID, 83707. 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.

Read your Policy 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 responsibilities of both you and Blue Cross of Idaho.

Notice

The policy you choose may not fully cover all of your medical costs. Blue Cross of Idaho's Medicare supplement programs and its Independent Producers (Agents) are not affiliated with Medicare. This summary only briefly describes Medicare benefits. Consult your local Social Security Administration office or consult "The Medicare Handbook" for more details.

Policy Information

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.

VISIT OUR WEB SITE AT WWW.BCIDAHO.COM OR CALL YOUR LOCAL BLUE CROSS OF IDAHO DISTRICT OFFICE TO FIND OUT WHICH BLUE CROSS OF IDAHO MEDICARE SUPPLEMENT PLAN IS RIGHT FOR YOU.

Application/Enrollment Checklist

To enroll in a Blue Cross of Idaho Medicare supplement, simply follow the checklist below:

- ☐ Read and review both of the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance" sections. Sign the bottom of the form, and keep this with your contract.
- ☐ Accurately complete the first 3 pages of the application, including all pertinent medical information if you are not enrolling during Open Enrollment.
- ☐ ***Make sure there are no boxes left unmarked, and there is no information missing.***
- ☐ Sign and date the "Applicant's Statement" on the bottom of the third page.
- ☐ Include a copy of your Medicare identification card if you are:
  - under 65 and disabled; or
  - applying for a Medicare supplement and this is **not** the first time you have enrolled in a supplement program.
- ☐ Remember to include your first month's premium if you are applying for Automatic Bank Withdrawal.
- ☐ Remove the application from the booklet.
- ☐ Mail the application to Blue Cross of Idaho.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance

Save this notice! It may be important to you in the future!

According to your application or information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Blue Cross of Idaho. Federal and state law provides 30 days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you have now. Terminate your present policy only if, after due consideration, you find the purchase of this Medicare supplement coverage is the choice you wish to make. Keep in mind:

1. You do not need more than one Medicare supplement policy.
2. If you are 65 or older, you may by eligible for benefits under Medicaid and may not need a Medicare supplement policy.
3. The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 hours. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstated if we receive your request within 90 days of losing Medicaid eligibility.
4. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

Notes

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance

Save this Notice! It may be important to you in the future!

According to your application or information you have furnished, you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by Blue Cross of Idaho. Federal and state law provides 30 days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find the purchase of this Medicare supplement coverage is the choice you wish to make.

State to Applicant by Agent (Independent Producer or Other Representative):

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

❑ Additional benefits

❑ No charge in benefits, but lower premiums

❑ Fewer benefits and lower premiums

❑ Other (please specify)____

____

____

If you still wish to terminate your present policy and replace it with new coverage, be certain to completely and accurately answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. ***After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.***

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

____

Signature of Agent, Independent Producer, or Other Representative

____

Type or print name and address of Insurer, Agent, or Independent Producer and phone number

The above “Notice to Applicant” was delivered to me on:____________________

Date

____

Applicant’s Signature

Medicare Supplement Application

Application Information

Your Name *(first, initial, last)*	Date of Birth *(mm/dd/yy)* / /	Age	Height	Weight	❑ Male ❑ Female
Mailing/Billing Address *(street or route)*	City, State, Zip Code				

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed	Do you or have you ever smoked or used tobacco in the past 12 months? ❑ Yes ❑ No	Phone Number

Are you applying during open enrollment? ❑ Yes ❑ No	Do you have Part A of Medicare? ❑ Yes Effective Date ____ ❑ No Do you have Part B of Medicare? ❑ Yes Effective Date ____ ❑ No		Medicare Number
Are you currently enrolled with Blue Cross or Blue Shield? ❑ Yes ❑ No	If yes, Identification Number	Headquarters City and State	Social Security Number / /

We require a copy of the front and back of your current Medigap or Medicare Advantage enrollment card to determine eligibility for our programs. Failure to provide this information will result in a delayed effective date of this new coverage until this information is obtained.

Program Information

❑ ***Classic Blue***℠ – Plan F ❑ ***Classic Blue***℠ – Plan C ❑ ***Classic Blue***℠ – Plan A ❑ ***Classic Blue***℠ – Plan J
❑ ***Classic Blue***℠ – Dental Requested Effective Date:________________________

The effective date on the policy will be the 1st of the month following receipt and acceptance of the application by the Blue Cross of Idaho Underwriting Department.

If, after health statement review, I am not eligible for my selection marked above, please consider me for:
(First choice) ________________________________ *(Second choice)* ________________________________

❑ Do not enroll me. Please refund my payment.

Mode of Payment

❑ Monthly Automatic Bank Deduction **Direct Pay Statements:** ❑ Monthly *($2.00 monthly billing fee will apply.)*

(First month's premium is required for all new applications. For automatic bank deductions, please include a voided check and sign the authorization agreement on the back of next page.)

Independent Producer Statement

- I hereby certify that I personally solicited and completed this application, that I personally asked each question on this application, and have accurately recorded the answers;
- That the answers to all of the questions are complete and accurate to the best of my knowledge and belief;
- That I have explained the eligibility provisions to the applicant and have not made any representations about benefits, conditions, or limitations of the policy, except through written material furnished by Blue Cross of Idaho;
- That I have verified the dates on the applicant's Medicare card.

Type of Company Appointment: ❑ Personal ❑ Agency (Name) ________________________________

________________ ________________ ________ ________ ________
Independent Producer's Printed Name *Independent Producer's Signature* *Date* *Phone No.* *Blue Cross of Idaho No.*

Office Use Only

Program Number	Enrollee ID	Effective Date	Cr. Days	End Date	Class	Plan
Reason Code	Risk	Smoker	Bill Mode	Payment Received	Receipt ID	Auditor

Form No. 3-334 (11-06)

An Independent Licensee of the Blue Cross and Blue Shield Association

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Other Carrier Information

Blue Cross of Idaho is currently considering a Medicare supplement application for the insured named below. The policy may or may not replace an existing Medicare supplement policy.

Insurer ________________________________ Name of Insured: ________________________________

Name ________________________________

and ________________________________

Address: ________________________________

Other Carrier
Policy Number: ________________________________

Health Statement

(Disregard this section if you are applying during the Medicare open enrollment period or if you now have other Blue Cross of Idaho coverage and are applying for Classic Blue Plan A or C.)

Answer each question YES or NO. If YES, ***circle*** the specific condition. Then, in the chart below, write the number or letter in which the condition is listed, along with specific details.

A. Has any company refused or restricted insurance on the applicant within the last year? ❑ YES ❑ NO

B. Has the applicant been advised, in the past five years, to have surgery or hospitalization? ❑ YES ❑ NO

C. Has the applicant ever had or been told he or she has any of the following:

	YES	NO
1. Cancer, cyst, tumor, or tumorous growth *(malignant or benign)?*	❑	❑
2. Heart trouble, heart murmur, chest pain, stroke, or any other disorder of the blood or circulatory system?	❑	❑
3. An ulcer or any disorder or difficulty of the stomach, liver, intestines, or gall bladder?	❑	❑
4. Diabetes, thyroid disorder, or any disorder of the glands?	❑	❑
5. Convulsions, loss of consciousness, or paralysis?	❑	❑
6. Any disorder of the kidneys, bladder, or prostate?	❑	❑
7. Disease or disorder of the eyes?	❑	❑
8. Emphysema, tuberculosis, or removal of any part of lung?	❑	❑
9. Rheumatoid arthritis or osteoarthritis?	❑	❑
10. A physical examination, check-up, or doctor's visit within the past six months?	❑	❑
11. High blood pressure? *(If **YES,** last reading ______________)*	❑	❑
12. Has the applicant ever tested positive for HIV infection?	❑	❑
13. Does the applicant have any illness, condition, or irregular symptoms not named above?	❑	❑

Letter or Number	Injury or Sickness	Date	Treatment	Result	Medication dosage, frequency	Doctor and/ or Hospital

– FOR AGENT USE ONLY –

List policies you have sold to this applicant that are still in force. *(Use extra sheet of paper if necessary.)*

____

____

List policies you have sold to this applicant in the past five years that are no longer in force. *(Use extra sheet of paper if necessary.)*

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Authorization Agreement for Prearranged Payments

Authorization Agreement for Prearranged Payments

I authorize and request Blue Cross of Idaho (hereafter called Blue Cross) to effect payment for premiums I owe to Blue Cross as they become due by initiating debit entries (hereafter called deductions) to my account in the financial institution named (hereafter called the bank). I authorize and request the bank to accept any deductions initiated by Blue Cross to my account. Blue Cross assumes full responsibility for correctly informing the bank of the specific amount of each deduction. I may terminate this agreement at any time by notifying Blue Cross or the bank in writing. Termination will take effect after Blue Cross or the bank has received the written notice and had a reasonable amount of time to act on it.

Bank Name ____________________

Bank Address *(city, state)* ____________________

Customer Bank Account Number ____________________

Company I.D. Number: 0000500005

Signed ____________________ Date __________

Transit Routing No. | Account Number Information

I: | | | | | | | | | I | | | | | | | | | | | | | | | |

Transit ABA

Please attach a voided check for automatic bank withdrawal

Other Coverage

To the best of your knowledge:

1. Do you currently or have you had in the past another Medicare supplement policy or certificate in force *(including any health care service contract or health maintenance organization contract)?* ❑ **YES** ❑ **NO**
   - (a) If **YES**, with which company? ____________________
   - (b) In what state? ____________________
   - (c) What was the termination date of the policy? ____________________
   - (d) What plan? (A-J) ____________________
2. Do you have any other health insurance policies or certificates that provide benefits that this Medicare supplement policy would duplicate? ❑ **YES** ❑ **NO**
   - (a) If **YES**, with which company? ____________________
   - (b) What kind of policy or certificate? ____________________
3. If the answer to question 1 or 2 is **YES**, do you intend to replace these policies or certificates with this policy? ❑ **YES** ❑ **NO**
4. Are you covered by Medicaid? ❑ **YES** ❑ **NO**

Applicant's Statement

- I understand and agree that the statements and answers on this Application and Health Statement are complete and accurate, and that any false statement, misrepresentation, or concealment of fact may, at the option of Blue Cross of Idaho, bar recovery of any benefits, and shall be grounds for voidance or cancellation of the policy.
- I acknowledge and understand my health plan may request or disclose health information about me from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Blue Cross of Idaho Notice of Privacy Practices that is available at ***www.bcidaho.com.***
- I understand and agree that the deposit, $ __________ *(if any)*, submitted with the Application is not binding upon Blue Cross of Idaho for the benefits applied for herein until the Application is approved; after approval the deposit then is payment of premiums for ____________________ month(s) from the effective date.
- The "Notice to Applicant" and *Outline of Coverage* were furnished to me on ____________________
  Date

Applicant's Signature ____________________

For Independent Producers Only

Independent Producer Checklist

- ❑ Are the Medicare Part A and B effective dates filled in on the first page?
- ❑ Is the application completed in ink and signed by the applicant? (A dependent's signature is not acceptable.)
- ❑ Are all questions marked "yes" or "no?" (Check to make certain that specific condition(s), date(s) of occurrence, or date(s) last treated is (are) included and note if condition(s) is (are) resolved; make certain that condition explanation is complete; include prescription name, dosage, strength, duration and reason; if there are broken bones, are there any pins or hardware?)
- ❑ Is the Notice to Applicant Regarding Replacement of Medicare Supplement Insurance section signed and dated?
- ❑ Did the applicant indicate the program they are applying for? (Only one program is allowed.)
- ❑ Is height and weight noted for the applicant listed on the application?
- ❑ Is the requested effective date on the first page filled in?
- ❑ Is the Authorization Agreement for Prearranged Payments section filled out and signed, and a voided check attached, if monthly automatic bank withdrawal is requested in the Payment Option section?
- ❑ Are all payments attached to the front of the application?
- ❑ If one check is written for split applications, is a breakdown of amounts to apply to each application included?
- ❑ Does the payment include a $2.00 monthly billing fee if the applicant chose Monthly Direct Coupon?
- ❑ Did you verify eligibility on applicant's card?

Independent Producer Certification

1. Who actually completed this application? ❑ Applicant ❑ Independent Producer ❑ Other

   If Independent Producer or Other, please explain: ______________________________

2. Were you present at the time the application was filled out? ❑ **YES** ❑ **NO**

   If **NO**, please explain: ______________________________

3. Are you aware of any medical information relating to the applicant or any family member that has not been disclosed on this application? ❑ **YES** ❑ **NO**

   If **YES**, please explain: ______________________________

4. Was money collected from the applicant? ❑ **YES** ❑ **NO** **Amount $** ______________________________

I have explained the eligibility provisions to the applicant. I have not made any representations about benefits, conditions, or limitations of the policy except through written material furnished by Blue Cross of Idaho. I hereby certify that the information supplied to me by the applicant has been completely and accurately recorded.

Nena Swenson			**7001BC**
Independent Producer's Printed Name	*Independent Producer's Signature*	*Date*	*Blue Cross of Idaho No.*

Type of Company Appointment ❑ *Personal* ☒ *Agency (Name)* **Insurers of Idaho**

one TO one

It's a ratio that most-accurately represents
our dedication to unparalleled customer service and to you,
OUR NUMBER-ONE PRIORITY.

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(208) 395-8200 | (888) 494-2583

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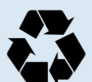

An Independent Licensee of the Blue Cross and Blue Shield Association

VISIT OUR WEB SITE AT WWW.BCIDAHO.COM