

MEDIFILSM ENROLLMENT APPLICATION

HIPAA COMPLIANT

**IMPORTANT: Please Read Carefully and Complete
All Information In Black or Blue Ink. Do not use pencil.**

- You do not need more than one Medicare supplement policy.
- If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- The benefits and premiums under your Medicare supplement policy will be suspended 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 policy will be reinstated if requested within 90 days of losing Medicaid eligibility.
- Counseling services may be available to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid by contacting the State of WV Health Insurance Assistance Program.

SECTION I (Personal Information)

NAME: LAST		FIRST	M.I.	SOCIAL SECURITY NUMBER		SEX M ___ F ___
ADDRESS (STREET NO., APT. NO., BOX NO., ETC.)					PHONE NUMBER	
CITY		COUNTY	STATE	ZIP	BIRTHDATE MO. DAY YR.	
BILL TO:	HOME ADDRESS _____	GROUP _____ GROUP # _____	FINANCIAL INSTITUTION _____ <i>(MUST FILL OUT ENCLOSED SURE PAY APPLICATION)</i>			

SECTION II (Eligibility)

I UNDERSTAND THAT IN ORDER TO BE ELIGIBLE FOR THE MOUNTAIN STATE MEDIFIL COVERAGE: I must be enrolled in both the hospital insurance (Part A) and medical insurance (Part B) portions of Medicare.

Effective date of my Medicare hospital insurance (Part A) is: _____ / _____ / _____
MONTH DAY YEAR

Effective date of my Medicare medical insurance (Part B) is: _____ / _____ / _____
MONTH DAY YEAR

My Medicare number is: _____ (This may be found on your red, white and blue Medicare card.)

An "Outline of Medicare Supplement Coverage" was sent to me with this Application. The Outline explains the coverage options available. My signature on this Application indicates that I have received the Outline.

I select the coverage option as indicated below:

- Medifil Plan A
 Medifil Plan C
 Medifil Plan F
 Medifil Plan I

Requested Effective Date: _____

FOR CURRENT BLUE CROSS BLUE SHIELD SUBSCRIBERS, THIS IS A:

REQUEST FOR A CONVERSION - My ID/Certificate Number is: _____

TRANSFER - I am presently covered by the Blue Cross Blue Shield plan located in _____ CITY

_____, my ID/Certificate Number is, _____
STATE

Indicate cancellation date of current contract, _____

SECTION III (Other Insurance Information)

Do you have a Medigap policy, Health Maintenance Organization (HMO) contract or Private Fee-For-Service Plan in force? If **YES**, with what company? _____ Yes No

Do you have any other health insurance policies that provide benefits that this Medicare Supplement policy would duplicate? If **YES**, a) With what company _____ Yes No

If the answer to either one of the questions above is yes, do you intend to replace these medical or health policies with this Policy? If **YES**, please complete the following information: Yes No

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):

Additional Benefits No change in benefits, Fewer benefits and lower premium but lower premium

Other, Please Specify _____

If you are 65 or older and on Medicare you are guaranteed the right to buy a Medigap policy if your other health insurance stops under certain criteria. If any of the following situations apply to you, please check that box and supply the information requested. To qualify for this guarantee you must apply for the new policy within 63 days of losing your other health coverage and provide documentation of this qualifying event.

You were enrolled in an employer supported group health plan with benefits that supplemented your Medicare benefits and the plan stopped providing those benefits.

If **YES**, please complete the following:

Enrollment Date _____ Discontinuation Date _____ Notification Date _____ Yes No

You were enrolled in a Medicare Health Maintenance Organization (HMO), Health Care Prepayment Plan (HCPP), Medicare SELECT Policy or Private Fee-For-Service Plan and your enrollment ended when you moved outside of the plan's service area, your plan's contract with Medicare ended or you elected to leave the plan.

If **YES**, please complete the following:

Enrollment Date _____ Discontinuation Date _____ Notification Date _____ Yes No

You were enrolled in a Medigap policy and coverage stopped because of the insolvency of the company, because of other involuntary termination of coverage (and there is no State law for continuing that coverage), or the company violated or misrepresented a provision of your policy.

If **YES**, please complete the following:

Enrollment Date _____ Discontinuation Date _____ Notification Date _____ Yes No

You choose to disenroll from the Medicare HMO, Medicare SELECT policy or Private Fee-For-Service Plan within 12 months of first enrolling.

If **YES**, please complete the following:

Enrollment Date _____ Discontinuation Date _____ Notification Date _____ Yes No

The Guarantee applies to you if:

- You were enrolled in Medicare.
- You had a Medigap policy and dropped it to enroll in a Medicare HMO, Medicare SELECT Policy or Private Fee-For-Service Plan for the first time.

The nature of the guarantee is more fully explained in the "Guide to Health Insurance for People on Medicare". If you have received a Letter of Creditable Coverage from a former insurer, please send a copy with your application.

Section IV (Medicaid and You)

Are you covered by Medicaid through the West Virginia Department of Health and Human Services? Yes No

If yes, please complete the following information:

Does Medicaid pay your Medigap premium? Yes No

Does Medicaid pay your Medicare Premiums, deductibles, and coinsurance? Yes No

Does Medicaid pay all or part of your Medicare part B premium? Yes No

If you are age 65 or over, and this Application is being submitted within six (6) months from the date you first enrolled for benefits under Medicare Part B (Part B effective date), you are converting from a Mountain State Blue Cross & Blue Shield policy or you are transferring from another Blue Cross and Blue Shield Plan, you may Disregard Section V. (Refer to Section I for your Medicare Part B effective date)

Section V (Health Screening)

Are you enrolled in Medicare due to a disability? Yes No

Are you presently confined to a hospital, skilled nursing facility or extended care facility or have you been so confined for more than five consecutive days within the last **twelve** months? Yes No

If yes, please explain the nature of the condition _____

Have you been advised that you will need to be admitted to a hospital, skilled nursing facility or extended care facility within the next **twelve** months? Yes No

If yes, please explain the nature of the condition _____

Within the last **two** years have you been diagnosed or received surgery or treatment (including prescription drugs) for or been advised to receive surgery or treatment for (including prescription drugs) any of the following?

Alzheimer's disease or Parkinson's disease Yes No

Lung disease (emphysema or chronic obstructive pulmonary disease) Yes No

Insulin dependent or complications of diabetes such as amputation or loss of sight Yes No

Cancer, Leukemia or Hodgkin's disease Yes No

Joint replacement or bone disorder (rheumatoid arthritis) Yes No

Kidney Dialysis or Transplant Yes No

Heart attack, stroke, bypass surgery or coronary artery disease Yes No

Immune disorder (Aids or Lupus) Yes No

SECTION VI

I have read the entire Application and by signing this Application, I declare that all information, statements, and answers are true and complete for all listed individuals applying for coverage. I also understand and agree that coverage, if issued, will be issued in full reliance on this Application and that any untrue or incomplete information, statements, and answers in this Application may result in the denial of a claim or rescission of coverage and may subject me to legal action by Mountain State Blue Cross & Blue Shield. I also understand under WV Code §33-41-3, "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." I also acknowledge that a copy of this Application shall be as valid as the original.

I acknowledge that no right whatsoever is created by this Application, and that I will not be covered by Mountain State Blue Cross Blue Shield unless and until this Application for coverage is approved and I have been provided with an Effective Date and Identification Number, and only as long as I continue to qualify under the terms of this policy with MSBCBS, including timely payment of premiums.

I also understand and agree that if any changes in my health status occur prior to the effective date, I will promptly notify MSBCBS.

Applicant's Signature _____ Date _____

I certify that I understand the contents of this application and the information stated herein are true and correct and I will notify Mountain State Blue Cross & Blue Shield of any changes

Agents Name (Please Print) _____ Signature _____ Date _____

OFFICE USE ONLY (DO NOT WRITE IN THE SPACES BELOW)

Sales Received Date	Underwriting Received Date	Membership Received Date (1)
U/A RQ Date	Membership Received Date (2)	On INSINQ
U/A Rcv RQ Date		INQUIRY CLOSED
Completed or Closed	Verified	ID Mailed

Date Approved _____
Approved By _____
Date Denied _____
Coverage Effective Date _____
This is a Waiver _____
Date Rec'd by Membership _____
Date on System _____
INSINQ Inquiry Number _____

Send to:

MOUNTAIN STATE BLUE CROSS BLUE SHIELD

P.O. Box 1948

Parkersburg, WV 26102