Application Instructions For Blue Shield of California

Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK.
Be sure you follow the instructions on the application carefully.
1. Print all pages of the application including instructions.
2. Complete all questions.
If you have any questions, or you are not sure how to answer a question, simply contact us : Tel. **(818)987-5000 fax: (818)776-9865**

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy
18440 Hatteras St. 210
Tarzana , CA 91356

Please make your check payable to: Blue Shield of California

If you have questions please contact us :

Oleg Skurskiy
Authorized Independent Agent
Tel.: 1-818-987-5000
Fax: 1-818-776-9865
oleg@askoleg.com

Thank you for choosing... Blue Shield of California

FOR OFFICE USE ONLY

Accept. Code_____

Plan Type_____

Market Code_____

Blue Shield of California

An Independent Member of the Blue Shield Association

Blue Shield Of California
Application To Transfer To A Medicare Supplement Plan

TRANSFERRING IS AS EASY AS 1-2-3!

1. Provide ALL requested information and print clearly in ink. Sign and date at the end.
2. Within 30 days of your signature date, mail the application in the postage-paid envelope enclosed. Keep the yellow copy for your records.
3. Please submit your first payment along with your application.

If you have questions about how to enroll, please call us at (**800) 248-2341** (TDD: (**800) 241-1823**).

You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

PERSONAL INFORMATION

First Name _____ Middle Initial _____ Last Name _____

Home Mailing Address _____

Home City _____ Home State _____ Home Zip _____

Home Telephone (_____) _____ E-mail _____ Sex ☐ Male ☐ Female

Billing Address (if different from above) _____

Date of Birth ☐☐ - ☐☐ - ☐☐☐☐ (MONTH - DAY - YEAR)

Language Preference

☐ English ☐ Spanish ☐ Chinese ☐ Other_____

Please check the Plan Type you are applying for: ☐ A ☐ B ☐ C ☐ D ☐ F ☐ H ☐ I

Requested Effective Date: The ☐ 1st day or ☐ 15th day of ☐☐ (MONTH) - ☐☐☐☐ (YEAR)

Medicare Number _____ Social Security Number _____

Blue Shield Member Number _____

Medicare Hospital (Part A) Effective Date _____ Medical (Part B) Effective Date _____

GUARANTEED ACCEPTANCE

You are guaranteed acceptance into a Medicare Supplement plan under Situation #1 as described in Blue Shield's Guaranteed Acceptance (GA) Guide, if you are within 6 months of your 65th birthday and your Part B effective date, or if you already have Medicare because you are disabled and have just turned 65. If you don't qualify for Situation #1, you may qualify for other GA situations that are listed in Blue Shield's GA Guide. Please read this guide and complete the statement below:

I believe I qualify for guaranteed acceptance based on situation number ☐.

CURRENT HEALTH PLAN INFORMATION

To the best of your knowledge:

1. ☐ Yes ☐ No Do you have another Medicare supplement plan contract or policy in force?
   - (a) If yes, with which company? _____
   - ☐ Yes ☐ No (b) If yes, do you intend to replace your current Medicare supplement policy or contract with a Blue Shield Medicare Supplement Plan? (If you currently have a Medicare Supplement plan, please complete and return the Replacement of Medicare Supplement Coverage form with this application.)
2. ☐ Yes ☐ No Do you have any other health care coverage that provides benefits similar to this Blue Shield Medicare Supplement Plan?
   - (a) If yes, with which company? _____
   - (b) What kind of coverage? _____
3. ☐ Yes ☐ No Are you covered for medical assistance by Medi-Cal?
   - ☐ Yes ☐ No (a) As a specified low-income Medicare beneficiary (SLMB)?
   - ☐ Yes ☐ No (b) As a qualified Medicare beneficiary (QMB)?
   - ☐ Yes ☐ No (c) For other Medi-Cal or Medicaid medical benefits?

MSP-15571-LO (8/04)

BILLING INFORMATION

Please include your first payment along with your application. To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement Plans Summary of Benefits and Provisions. You will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, Health Service Agreement and member identification card as proof of approval.

Select your payment choice:

☐ Easy$Pay℠ (automatic monthly debit - you must complete the enclosed form)

☐ I already participate in Blue Shield's Easy$Pay and would like to continue my authorization for premium payments for the new plan in which I am enrolling.

☐ Quarterly billing ☐ Monthly billing

TERMS, CONDITIONS AND AUTHORIZATIONS

Information Regarding Medicare Supplement Coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.

1. You do not need more than one Medicare Supplement plan policy or contract.
2. If you purchase a Blue Shield Medicare Supplement Plan contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3. You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement plan policy or contract.
4. The benefits and dues under your Blue Shield Medicare Supplement Plan can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your plan contract or policy will be reinstated, if requested, within 90 days of losing Medi-Cal eligibility.
5. Counseling services are available in California to provide advice concerning your purchase of Medicare Supplement coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). Information regarding counseling services may be obtained from the State Department of Aging.

Conditions of Membership:

1. This application will become part of the Evidence of Coverage for which I am applying, and together with any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2. I will receive no coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.
3. Only Blue Shield can approve this application. I understand that any insurance agent, broker or Sales Representative cannot grant approval, change terms or waive requirements.
4. Authorization for Disclosures of Personal Information: I authorize any "provider of care," insurer or health plan to disclose to Blue Shield of California, or its representatives, and vice versa, all "medical information" (as those terms are defined in the California Civil Code) regarding me, including medical information regarding substance abuse or mental/emotional conditions. This information may be used for evaluating this application, determining eligibility for benefits, and/or for quality assurance and peer review, and administrative functions reasonably related to executing and managing this Agreement. This authorization will remain valid as follows for the term of the coverage or for as long as may be necessary for processing of claims incurred during coverage. I understand that I am entitled to a copy of this application and that a photocopy is as valid as the original.

I acknowledge receipt of the Summary of Benefits, the "Guide to Health Insurance for People with Medicare" and a copy of this application. I have read the Summary of Benefits and the terms, conditions and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

_____

Applicant's Signature Date

REPRESENTATIVE INFORMATION

Agent/Broker Name_____ Oleg Skurskiy_____

Agent/Broker ID _____ 0570_____ Agent/Broker Phone # _ 818-987-5000_____

List all policies or plan contracts sold which are still in force:_____

List all policies or plan contracts sold in the past five (5) years that are no longer in force:_____

_____

White copy: Give to your Blue Shield Agent or mail to Blue Shield's Underwriting Department with your first payment.
Yellow copy: Keep with your important Blue Shield information.