

Enrolling is Simple. 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. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department
at: _____ fax: _____

Step 2

SELECT THE TYPE OF BILLING YOU WANT – Monthly

Step 3

SEND THE COMPLETED APPLICATION TO:

Please make your check payable to: Blue Shield of California

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.

If you have questions please contact our office at:

Thank you for choosing...



Blue Shield of California
An Independent Member of the Blue Shield Association

Application for
Blue Shield of California
Medicare Supplement Plans



FOR OFFICE USE ONLY
Accept. Code _____ Plan Type _____ Market Code _____

Here's how to apply

- 1 Provide ALL requested information and print clearly in ink.
- 2 Sign and date in all places indicated.
- 3 Within 30 days of your signature date, mail the application in the enclosed postage-paid envelope. Keep the yellow copy for your records.
- 4 Please submit your first payment along with your application. Blue Shield will refund your payment if your application is not approved.

If you have questions about how to enroll, please call us at **(888) 713-0000** or TDD: (888) 595-0000.

Personal Information

First name	Middle initial	Last name
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Home address

City	State	ZIP
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Mailing address (if different from above)

City	State	ZIP
------	-------	-----

Home telephone ()	E-mail address
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Billing address

City	State	ZIP
------	-------	-----

Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth ____ - ____ - ____ Month Day Year
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Medicare number	Social Security number
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I'm entitled to: Hospital (Part A) effective date _____
 Medical (Part B) effective date _____

Please check the plan type you are applying for: A B C D F K

Requested effective date: The 1st day or 15th day of ____ - ____ - ____
Month Year

Language Preference English Spanish Chinese Other _____

Medicare prescription drug plan information

Have you purchased a Medicare Prescription Drug Plan? Yes No

- If Yes,**
- a. With what company?
 - b. What is the effective date?

Guaranteed acceptance

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Blue Shield Guaranteed Acceptance Guide, in the box below. Then attach proof of prior coverage as a separate sheet, and sign and date the sheet.

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

If applying for Guaranteed Acceptance under situation No. 2 on the enclosed Blue Shield Guaranteed Acceptance Guide, please complete the Notice of Replacement of Coverage form and submit with your completed enrollment application.

Current health plan information

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 contract or that you had certain rights to buy such a contract, 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 answer all questions. (Please mark Yes or No below with an X.) To the best of your knowledge.

- 1** Yes No a. Did you turn 65 years of age in the last 6 months?
 Yes No b. Did you enroll in Medicare Part B in the last 6 months?
c. If yes, what is the effective date? _____

- 2** Yes No Are you covered for medical assistance through California's Medi-Cal program?
NOTE TO APPLICANT: If you have a share of cost under the Medi-Cal program, please answer NO to this question.

If Yes,

- Yes No a. Will Medi-Cal pay your premiums for this Medicare supplement contract?
 Yes No b. Do you receive benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?

- 3** Yes No If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave the end date blank.
Start ____/____/____ End ____/____/____

If Yes,

- Yes No a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement contract?
 Yes No b. Was this your first time in this type of Medicare plan?
 Yes No c. Did you drop a Medicare supplement contract to enroll in the Medicare plan?

- 4** Yes No Do you have another Medicare supplement policy or certificate or contract in force?

If Yes,

- Yes No a. With what company, and what plan do you have?
b. Do you intend to replace your current Medicare Supplement policy or certificate with this contract?

- 5** Yes No Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)? If so, what companies and what kind of policy?
Carrier Name: _____ Carrier Phone No.: _____
Current ID No.: _____
What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the end date blank.) Start ____/____/____ End ____/____/____

- 6** Yes No Did you have Medicare coverage before age 65?
If Yes,
 Yes No a. Why? _____
b. What is the current status? _____
c.) Do you have end stage renal disease?

Statement of health

If you qualify for enrollment on the basis of guaranteed acceptance, you are not required to complete this section. Please answer Yes or No to each question.

1 Have you, within the past three years, received treatment or been hospitalized for any of the conditions listed below? If Yes, please explain the condition and indicate date of treatment at the end of this section.

- Yes No Brain or nervous system disorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.
- Yes No Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.
- Yes No Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.
- Yes No Gastrointestinal disorders such as liver cirrhosis, hepatitis B or C, ulcerative colitis, etc.
- Yes No Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.
- Yes No Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*
- Yes No Cancer or malignant tumors.
- Yes No Have you received treatment or been hospitalized for any other condition than those listed above?

2 Yes No Do you have a pacemaker or artificial heart valve or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate date of treatment at the end of this section.

3 Yes No Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If "Yes," please explain the confinement and indicate date of confinement at the end of this section.

4 Yes No Are you currently taking medication? If Yes, please list at the end of this section all medications you are currently taking and the condition for which the medication is prescribed.

If you answered Yes to any of the above questions, please provide additional information and dates associated with the condition, as well as current status of the condition. If additional space is required, please use additional sheets as necessary and sign and date each sheet.

Condition or medication	Date	Explanation/current status

*California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

You and your spouse or domestic partner may qualify for a TWO-PARTY CONTRACT.

Both individuals must be age 65 or older, enrolled in both Medicare Parts A and B, and apply for the same plan type. Either person who does not qualify for guaranteed acceptance (see below) will be subject to underwriting.

1 If you and your spouse/domestic partner are applying for a two-party contract, please check this box:

2 Is your spouse/domestic partner currently enrolled in a Blue Shield Medicare Supplement plan? Yes No

a. If Yes, which Plan Type? _____ Please provide your spouse/domestic partner's name and Social Security number below.

b. If No, and you are both currently applying for coverage, you and your spouse/domestic partner must each complete your own application. On each application, please provide your spouse/domestic partner's name and Social Security number.

Name of spouse/domestic partner:

Spouse/domestic partner's Social Security number:

Payment 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. If you are not approved, Blue Shield will refund your payment amount. If your application is approved, 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\$PaySM (automatic monthly debit – you must complete the enclosed form)
 Credit card payment (automatic monthly or quarterly charge – you must complete the enclosed form)
 Quarterly billing Monthly billing

Please enclose only one check for the applicable two-party rate, which can be found in the Summary of Benefits.

Check enclosed with this application
 Check enclosed with spouse/domestic partner's application

You may 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.

Terms, conditions, and authorizations

Information regarding Medicare supplement plan 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 this 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 or Medicaid and may not need a Medicare Supplement contract.
- 4** If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare supplement contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare supplement contract or if that is no longer available, a substantially equivalent contract, will be reinstated if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 5** If you are eligible for, and have enrolled in, a Medicare supplement contract 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 contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement contract — or if that is no longer available, a substantially equivalent contract — will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement contract provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your contract was suspended, the reinstated contract 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 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 and the Statement of Health, together with the *Evidence of Coverage and Health Services Agreement* and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
- 2** I will not receive 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** 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

By signing below you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you chose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid 1) for thirty (30) months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation. **If you qualify for enrollment on the basis of guaranteed acceptance, you are not required to sign this release for enrollment in a Medicare supplement plan.**

Signature

Date

Dental PPO Plans

Affordable dental options for Medicare supplement members.

To sign up for Blue Shield dental by selecting a plan below, please provide the following information:
(dental coverage must have an effective date of 4/1/07 or greater)

Dental plan options (check one):

Dental PPO 1000

Dental PPO 1500

No dental plan

Conditions of coverage

Dental PPO benefits are separate from the medical benefits of Blue Shield's health plans. Except for the following, the general provisions and exclusions of the health plan apply:

- Dental benefits aren't subject to health plan deductible requirements.
- The Blue Shield dental PPO plans are underwritten by Blue Shield of California and administered by Dental Benefit Providers of California Inc.
- If your dental coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reinstatement, but you will have to wait 12 months to reapply.
- If your health plan coverage is terminated or cancelled, your dental coverage is terminated, as well.

For two-party enrollment

If you are enrolling in a Medicare Supplement plan with a two-party contract, you may enjoy the convenience of a single bill and lower rates for you and your spouse/domestic partner. Keep the same convenience when you choose your dental plan by matching your dental plan enrollment with your Medicare Supplement enrollment. You and your spouse/domestic partner need to select the same dental PPO plan to receive one bill that may include the lower Medicare Supplement rates bundled with your dental rates.

Producer Information

Agent/Broker Name

Agent/Broker ID

Agent/Broker Phone No.

Agent/Broker Fax No.

Agent/Broker Address

Agent/Broker Signature

Please list any other health insurance policies or plan contracts they have sold to the applicant as follows:

List policies and plan contracts sold that are still in force _____

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

®Blue Shield and the Shield symbol are registered marks of the Blue Cross Blue Shield Association, an Association of Independent Blue Cross and Blue Shield Plans. Easy\$PaySM is a service mark of Blue Shield of California.

Medicare Supplement automatic payment form

What is Easy\$Pay?

Easy\$PaySM is a simple, convenient way to pay your dues. Simply authorize Blue Shield to withdraw the monthly dues from your personal checking or savings account. By choosing this method, you will save \$2 per month on your plan dues.

How does credit card payment work?

With credit card payment, you authorize Blue Shield to charge your monthly or quarterly dues to your Visa or MasterCard.

Visit us at
blueshieldca.com

The automatic payment advantage

With Easy\$Pay or credit card payment, you won't be concerned about paying on time. There is no check to write, no postage to pay and this service is offered, to you at no extra charge.

Here's all you do

Complete the attached automatic payment authorization form and send it back to:

Blue Shield of California
P.O. Box 629013
El Dorado Hills, CA 95762-9013

To use your Visa or MasterCard:

Just complete the form attached to charge your monthly or quarterly dues to your credit card.

To use Easy\$Pay:

Complete the form and enclose a check for your first month's dues along with a blank check or deposit slip marked "void." This will be used as a record of your account number, your bank's routing/transit number, and other necessary information. If you prefer not to attach a voided check or deposit slip, you must provide your bank account number and the routing/transit number of your financial institution (see illustration below).

Mary Jane Blue 123 First St. Anytown, CA 99999	3025
Pay to Order of	_____20__
Any Bank San Francisco Main Office P.O. Box 8944 San Francisco, CA 94126 Memo	Dollars
032056884 9 8707228001 0233	_____
Bank Account Number	
Bank Routing/Transit Number	

Continue to submit your monthly dues until you receive notice from Blue Shield that your automatic payment has been accepted.

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Medicare Supplement Automatic Payment Authorization Form

I am: a new Automatic Payment applicant a current Automatic Payment user reporting a change (requires 30-day notice)

Easy\$Pay* Debit Date: 1st of month, or 15th of month

Name of subscriber	Subscriber's daytime phone number
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Mailing Address	City	State	ZIP Code
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Checking or Savings Account Debits*

Note: If you're requesting Easy\$Pay and you're sending a voided check or deposit slip, you don't need to complete the following.

Type of account: Checking Account Savings Account

Bank Routing/Transfer # _____

Bank Account Number _____

Name of Financial Institution _____

Name(s) on Bank Account _____

Branch Address	City	State	ZIP Code
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Branch Telephone # _____

Credit Card Payments* (Credit card will be billed on the first of the month)

Type of account: Visa MasterCard Monthly Charge Quarterly Charge

Cardholder Name _____

Cardholder Billing Address	City	State	ZIP Code
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Account	Credit Card #	Expiration Date
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*You will be charged the amount owed for dues/premium until you choose to cancel your automatic payment schedule. If you choose to cancel your automatic payment, or if changes are made to the account being charged, please call one of our Customer Service Representatives today at (800) 248-2341 (TDD: 888-595-0000), Monday through Thursday, 8 a.m. to 5:30 p.m. and 9 a.m. to 4:30 p.m. on Friday (excluding holidays). Credit card debit may occur 1 to 2 days prior to payment date.

I authorize my health plan, Blue Shield of California, to initiate debits/charges (and/or corrections to previous debits/charges) from my account with the financial institution/credit card institution identified by me on this form or voided check or deposit slip for payment of my Blue Shield dues, as well as for the dues of the following covered individuals:

Subscriber Number _____
 Subscriber Number _____

I also authorize that financial/credit card institution to reduce/charge the balance of my account by the amount of those debits/charges (and/or corrections to previous debits/charges) on the agreed upon schedule. This authorization will remain in effect **until I** provide notice revoking the authorization by calling Customer Service at (800) 248-2341 at least 10 days before my account is to be debited/charged.

Authorized Signature(s) – as it/they appear in the financial/credit card institution's records. If the account is listed as a joint account, both account holders must sign. If the holder of the account is not an individual, the one signing on behalf of the company/partnership/etc. must identify him/herself and his/her relationship to the company/partnership.

Signature _____ Date _____

Print name _____ Relationship _____

Signature _____ Date _____

Print name _____ Relationship _____

guaranteed-acceptance guide

Blue Shield of California Medicare Supplement plans

If you have recently become eligible for Medicare, or lost or ended your health coverage with another plan, you may qualify for guaranteed acceptance in a Blue Shield Medicare Supplement plan in certain situations. This guide will help you determine whether you qualify for guaranteed acceptance. **If you are age 64 or younger with end-stage renal disease, you are not eligible to enroll.**

Important: Please note that this guide is only a summary, and is intended to help you identify the different situations that may qualify you for guaranteed acceptance in a Blue Shield Medicare Supplement plan. It does not contain all the details of each situation. It's important to remember that laws regulating guaranteed acceptance plans change frequently. Consequently, some information in this guide may no longer be accurate. Please ask your sales representative or your attorney to confirm that you qualify for guaranteed acceptance.

If you and your spouse or domestic partner are applying for a two-party rate contract, both individuals must be age 65 or older, be enrolled in both Medicare Parts A and B, and apply for the same plan type. Even under a two-party rate contract, each individual must qualify for guaranteed acceptance to apply. Either person who does not qualify for guaranteed acceptance according to the Guaranteed Acceptance Guide will be subject to underwriting.

For more information about guaranteed acceptance, please contact Blue Shield at the following numbers:

(800) 248-2341, TTY/TDD **(800) 241-1823**

8 a.m. to 5 p.m., Monday through Thursday, and 9 a.m. to 5 p.m. Friday, excluding holidays

Or, contact your agent or your Blue Shield sales representative at:

Woodland Hills Regional Sales Office

(888) 713-0000, TTY/TDD **(888) 585-0000**

8:30 a.m. to 5:30 p.m., Monday through Friday, excluding holidays

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.

How to use this guide:

1. If you believe a situation applies to you, review your plan choices and when to apply.
2. Decide which plan choice you want to apply for, based on plan descriptions found in Blue Shield's *Summary of Benefits and Provisions* booklet.
3. Write the corresponding situation number in the Guaranteed Acceptance section of your application.

Applicants who qualify for enrollment on the basis of guaranteed acceptance are not required to complete the Statement of Health portion of the Medicare Supplement Application. Applicants who do not qualify for guaranteed acceptance must complete the Statement of Health.

4. If you believe you qualify for guaranteed acceptance, please attach proof of prior coverage as outlined in the table at the end of this guide.
5. Do not return this guide with your application. Keep it as a reference along with your other important Blue Shield materials.

1	Situation	You are: <ul style="list-style-type: none"> • Enrolled in Medicare and are age 65 or older; or • You are new to Medicare, are age 64 or younger, and do not have end-stage renal disease.
	Your plan choices	<ul style="list-style-type: none"> • If you are age 65 or older: Plan A, B, C, D, F, G, J, or K • If you are age 64 or younger: Plan A, B, C, F, J, or K
	When to apply	<ul style="list-style-type: none"> • If you are age 65 or older: Blue Shield must receive your application within 6 months, beginning with the first day of the first month in which you are both 65 years of age or older, and you are enrolled for benefits under Medicare Part B. • If you are age 64 or younger: Blue Shield must receive your application within 6 months of your enrollment in Medicare Part B, or if you are notified retroactively of eligibility for Medicare, within 6 months of notice of eligibility.
2	Situation	You currently have a Medicare Supplement plan and want to switch to a different Medicare Supplement plan.
	Your plan choices	You have an annual open enrollment period, during which you may transfer to any Medicare Supplement plan that offers benefits equal to or lesser than those provided in your current plan. Call Blue Shield at (800) 248-2341 to see which plans you qualify for.
	When to apply	Blue Shield must receive your application within 30 days of your birthday.

3	Situation	<p>You enrolled in one of the following plans:</p> <ul style="list-style-type: none"> • A Medicare Advantage¹ plan; • A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999; • A healthcare prepayment plan; • A Medicare Select policy; <p>and any of the following apply:</p> <ul style="list-style-type: none"> • The certification of the organization or plan is being terminated; • The organization is terminating or discontinuing the plan in the service area in which you reside; or • You are no longer eligible because you moved outside the service area.
	Your plan choices	Plan A, B, C, F, or K
	When to apply	If your coverage is being involuntarily terminated, ² you may submit your application any time after you receive the notice of termination, but no later than 63 days after the date coverage is terminated; however, if you are enrolled in a Medicare Advantage plan, you must apply within 123 days of the date your coverage is terminated.

4	Situation	You received notice of termination, or your coverage was terminated from any employer-sponsored health plan, including an employer-sponsored retiree health plan. This includes termination for loss of eligibility due to divorce or death of a spouse.
	Your plan choices	<ul style="list-style-type: none"> • If you are age 65 or older: Plan A, B, C, D, F, G, J, or K • If you are age 64 or younger: Plan A, B, C, F, J, or K
	When to apply	Blue Shield must receive your application within 6 months of the notice of termination, or if no notice is received, within 6 months of the date your employer-sponsored health coverage ended.

5	Situation	You enrolled in a Medicare Supplement plan, but you lost coverage because you moved outside the plan's service area.
	Your plan choices	<ul style="list-style-type: none"> • If you are age 65 or older: Plan A, B, C, D, F, G, J, or K • If you are age 64 or younger: Plan A, B, C, F, J, or K
	When to apply	Blue Shield must receive your application within 6 months of the date coverage is terminated.

6	Situation	You enrolled in a Medicare Advantage plan, ^{1,3} or a Program of All-Inclusive Care for the Elderly (PACE) provider plan at age 65, and disenrolled from the plan within 12 months of the effective date of that enrollment.
	Your plan choices	Plan A, B, C, D, F, G, J, or K
	When to apply	<ul style="list-style-type: none"> • If your coverage is being involuntarily terminated,² you may submit your application any time after you receive the notice of termination, but no later than 63 days after the date coverage is terminated; however, if you are enrolled in a Medicare Advantage plan, you must apply within 123 days of the date coverage is terminated. • If you are voluntarily terminating your coverage, you may submit an application 60 days before the effective date of termination, but your application must be received within 63 days of the date coverage is terminated.

7	Situation	<p>You were enrolled in a Medicare Supplement plan and subsequently enrolled in a Medicare Advantage plan,^{1,3} or a PACE provider plan and:</p> <ul style="list-style-type: none"> • Your coverage was involuntarily terminated within 12 months of the effective date of that enrollment; and • You then enrolled in another Medicare Advantage or PACE provider plan and disenrolled from that plan within 24 months of the effective date of the first plan.
	Your plan choices	<ul style="list-style-type: none"> • Plan A, B, C, F, or K; or • The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.
	When to apply	If your coverage is being involuntarily terminated, ² you may submit your application any time after you receive the notice of termination, but no later than 63 days after the date coverage is terminated; however, if you are enrolled in a Medicare Advantage plan, you must apply within 123 days of the date coverage is terminated.

8

Situation	<p>You are 65 or older, are enrolled in a PACE provider plan, and any of the following situations that permit termination of enrollment in that plan apply:</p> <ul style="list-style-type: none"> • The certification of the organization or plan is being terminated. • The organization is terminating or discontinuing the plan in the service area in which you reside. • You are no longer eligible, because you moved outside the service area. • The organization substantially violated a material provision of the contract with CMS. • The organization or its agent materially misrepresented a provision of the plan in marketing the contract to you.
Your plan choices	Plan A, B, C, F, or K
When to apply	<ul style="list-style-type: none"> • If your coverage is being involuntarily terminated,² you may submit your application any time after you receive the notice of termination, but no later than 63 days after the date coverage is terminated. • If you are voluntarily terminating your coverage, you may submit an application 60 days before the effective date of termination, but your application must be received within 63 days of the date coverage is terminated.

9

Situation	<p>You terminated enrollment in a Medicare Supplement plan and subsequently enrolled, for the first time, in any of the following:</p> <ul style="list-style-type: none"> • A Medicare Advantage plan;^{1,3} • A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999; • A PACE provider plan; or • A Medicare Select policy. <p>You then disenrolled from that plan, or coverage was terminated within the first 12 months.</p>
Your plan choices	<ul style="list-style-type: none"> • Plan A, B, C, F, or K; or • The Medicare Supplement plan you had previously, if it is still offered for sale by that insurer.
When to apply	<ul style="list-style-type: none"> • If your coverage is being involuntarily terminated,² you may submit your application any time after you receive the notice of termination, but no later than 63 days after the date coverage is terminated. • If you are voluntarily terminating your coverage, you may submit an application 60 days before the effective date of termination, but your application must be received within 63 days of the date coverage is terminated.

10	Situation	<p>You terminated enrollment in a Medicare Supplement plan and subsequently enrolled, for the first time, in any of the following:</p> <ul style="list-style-type: none"> • Any Medicare Advantage plan;¹ • A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999; • A PACE provider plan; or • A Medicare Select policy. <p>However, your coverage was involuntarily terminated no later than 12 months after the effective date of enrollment. You then enrolled in another similar plan and disenrolled from that plan within 24 months of the effective date of the first plan.</p>
	Your plan choices	<ul style="list-style-type: none"> • Plan A, B, C, F, or K; or • The Medicare Supplement plan you had previously, if it is still offered by that issuer.
	When to apply	<p>If your coverage is being involuntarily terminated,² you may submit your application any time after you receive the notice of termination, but no later than 63 days after the date coverage is terminated; however, if you are enrolled in a Medicare Advantage plan, you must apply within 123 days of the date coverage is terminated.</p>

11	Situation	<p>You enrolled in an employer-sponsored health plan that supplements Medicare, and the plan either terminates or ceases to provide all of those supplemental health benefits to you.</p>
	Your plan choices	Plan A, B, C, F, or K
	When to apply	<p>You may submit an application to Blue Shield any time from the later of the following:</p> <ul style="list-style-type: none"> • The date you received a notice of termination, or, if no notice is received, on the date of the notice denying the claim because of termination of benefits; or • The date coverage is terminated, but no later than 63 days from the date coverage is terminated.

12	Situation	<p>You are a Medicare-eligible military retiree or dependent, and you lost access to healthcare services because:</p> <ul style="list-style-type: none"> • The military base closed; • The military base no longer offers services; or • You relocated.
	Your plan choices	<ul style="list-style-type: none"> • If you are age 65 or older: Plan A, B, C, D, F, G, J, or K • If you are age 64 or younger: Plan A, B, C, F, J, or K
	When to apply	<p>Blue Shield must receive your application within 6 months of the date you lost access to healthcare services at the military base.</p>

13	Situation	<p>You enrolled in one of the following plans:</p> <ul style="list-style-type: none"> • A Medicare Advantage plan;^{1,3} • A Medicare cost or similar organization operating under demonstration project authority before April 1, 1999; • A healthcare prepayment plan; • A Medicare Supplement plan; or • A Medicare Select policy; <p>but coverage stopped because:</p> <ul style="list-style-type: none"> • The company substantially violated a material provision of the contract; or • The company or its agent materially misrepresented a provision of the plan in marketing the contract to you.
	Your plan choices	Plan A, B, C, F, or K
	When to apply	You may submit an application 60 days before the effective date of termination, but Blue Shield must receive your application within 63 days of the date coverage is terminated.

14	Situation	<p>You enrolled in a Blue Shield Medicare Advantage¹ plan, and Blue Shield either:</p> <ul style="list-style-type: none"> • Reduced any of its benefits; • Increased the amount of cost-sharing; or • Discontinued (for other than quality of care) a contract with a provider currently furnishing services to you.
	Your plan choices	Plans A, B, C, F, or K
	When to apply	You may submit an application 60 days before the effective date of termination, but Blue Shield must receive your application within 63 days of the date coverage is terminated.

15	Situation	<p>You enrolled in a Medicare Supplement plan, but coverage stopped because:</p> <ul style="list-style-type: none"> • The company filed for bankruptcy or is insolvent; or • Other involuntary termination of coverage under the contract.
	Your plan choices	Plan A, B, C, F, or K
	When to apply	<p>You may submit an application to Blue Shield any time from the later of the following:</p> <ul style="list-style-type: none"> • After the date you receive notice of termination, bankruptcy/insolvency or other similar notice; or • The date coverage is terminated, but within 63 days of the date coverage is terminated.

16	Situation	You are no longer eligible for Medi-Cal because of an increase in your income or assets.
	Your plan choices	<ul style="list-style-type: none"> • If you are age 65 or older: Plan A, B, C, D, F, G, J, or K • If you are age 64 or younger: Plan A, B, C, F, J, or K
	When to apply	Blue Shield must receive your application within 6 months of the date coverage is terminated.

End notes

1. A Medicare Advantage plan can be any of the following: a Medicare managed care (HMO) plan, Medicare Preferred Provider Organization (PPO) plan, Medicare private fee-for-service (PFFS) plan or specialized Medicare Advantage plan.
2. Involuntarily terminated coverage does not include termination for fraud or non-payment of dues.
3. If you are currently enrolled in a Medicare Advantage plan and have already made your selection for the current year, you may not be guaranteed acceptance into a Medicare Supplement plan. In that case you must remain in your Medicare Advantage plan until the next open enrollment period, which is November 15 through December 31, 2008, with an effective date of January 1, 2009.

If you apply for a Blue Shield Medicare Supplement plan under guaranteed acceptance provisions, you must provide documentation for certain situations, as follows:

For this situation	You must provide this documentation
1	<ul style="list-style-type: none"> • Medicare Parts A and B effective dates and your Medicare number. • In addition, if you are age 64 or younger, a signed and dated statement indicating you do not have end-stage renal disease.
2	A completed copy of Blue Shield's Notice to Applicant Regarding Replacement of Medicare Supplement coverage, plus proof of your current plan type.
3	A copy of the prior coverage termination notice.
4, 7, 9	A copy of the prior coverage termination notice that includes the termination date, plus proof of prior coverage.
5, 6, 10, 12, 13, 14, 15	A copy of the prior coverage termination notice and the reason for termination.
11	A copy of the prior coverage termination notice, including the reason for termination, or claims denial.