Excellus

Excellus Health Plan, Inc.
Attn: Medicare Enrollment Processing,
PO Box 31790, Rochester, NY 14603-1790

For Internal Use

Medicare Supplement Enrollment Form

(AA) - New Application (S) - Cancellation Date __/__/_____ (SR) - Subscriber Request

(AC) - Request Change (SD) - Subscriber Deceased

Coverage Selection (check one type of coverage)

Medicare Supplement A | Medicare Supplement B | Medicare Supplement C*

Medicare Supplement D | Medicare Supplement F* | Medicare Supplement F+*

Medicare Supplement G | Medicare Supplement G+ | Medicare Supplement N

* Available only to applicants first eligible for Medicare before January 1, 2020.

Requested Month For Coverage to Begin (coverage starts 1st of the month):

☐☐/☐☐☐☐

Employer Group Applicants Only

Group Name:

Group Number:

General Information (one person per application)

Name (Last Name, First Name, Middle Initial) Check if name change

Date of Birth ☐☐/☐☐/☐☐☐☐

Male **Female**

Day Phone ☐☐☐-☐☐☐-☐☐☐☐

Medicare ID Number

Part A Effective Date ☐☐/☐☐/☐☐

Part B Effective Date ☐☐/☐☐/☐☐

Mailing/Billing Address (street) Check if address change

City, State, Zip

County

Permanent Residence Street Address (if different from mailing address - PO box not allowed) **City, State, Zip**

Email Address (optional)

Choose Your Method of Payment

If you don't select a payment option, you will get a bill each month.

Please select a premium payment option:

Billing Cycle (Select One): Monthly Quarterly Annually

Get a bill.

Electronic Funds Transfer (EFT) from your bank account. Please enclose a VOIDED check or provide the following:

Account Holder Name:

Bank Routing Number:

Bank Account Number:

Account Type: Checking Savings

A nonprofit independent licensee of the Blue Cross Blue Shield Association

NOTICE TO APPLICANT: The sale of a Medicare supplement policy is prohibited where an individual has a Medicare supplement policy in force and does not desire to replace the existing policy, or where the Medicare supplement policy would duplicate benefits to which the individual is entitled under a Medicare Advantage plan.

Statements

- You do not need more than one Medicare supplement policy or certificate.
- If you purchase this policy (certificate), you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy (certificate).
- If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy (certificate) may be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (certificate) (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid Program, including benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB).

Questions To the best of your knowledge and belief: Please mark Yes or No below with an "X"

1. Did you turn age 65 in the last 6 months?	Yes	No
2. Did you enroll in Medicare Part B in the last 6 months? If yes, what is the effective date? _____	Yes	No
3. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.) If YES, answer both questions below.	Yes	No
• Will Medicaid pay your premiums for this Medicare supplement policy?	Yes	No
• Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	Yes	No
4. If you had coverage from any Medicare Advantage plan other than original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates to the right. If you are still covered under the Medicare Advantage plan, leave END DATE blank.	Start Date End Date	
• If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes	No
• Was this your first time in this type of Medicare Advantage plan?	Yes	No
• Did you drop a Medicare supplement policy to enroll in the Medicare Advantage plan?	Yes	No

If you have any questions, please call: 1-800-659-1986

Questions To the best of your knowledge and belief: Please mark Yes or No below with an "X"	
5. Do you have another Medicare supplement or Medicare Select policy or certificate in force?	Yes No
• If so, with what company and what plan do you have? _____	
• If so, do you intend to replace your current Medicare supplement or Medicare Select policy or certificate with this policy or certificate?	Yes No
6. Have you had coverage under any other health insurance policy or certificate within the past 63 days? (For example, an employer, union, or individual plan)	Yes No
• If so, with what company and what kind of policy? _____	
• What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave END DATE blank)	Start Date End Date

Note: A break in coverage of more than 63 days could result in enforcing waiting period for pre-existing conditions. Our Medicare supplement plans are subject to a six (6)-month waiting period for pre-existing conditions unless prior coverage affords credit for some or all of this time period.

I HAVE READ AND I UNDERSTAND THE QUESTIONS AND STATEMENTS ABOVE. ALL INFORMATION FURNISHED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED $5,000 AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

Applicant's Signature _____ **Date:**

Sales Agent/Broker Name _____ **NPN#** _____ **Agent ID #** _____

To be completed by Agent: *"I have reviewed the current health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs."* _____

Excellus BCBS Use Only	Group number	Package number	Effective Date (mm/dd/yy)

If you have any questions, please call: 1-800-659-1986

Notice of Nondiscrimination

Our Health Plan complies with federal civil rights laws. We do not discriminate on the basis of race, color, national origin, age, disability, or sex. The Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please refer to the enclosed document for ways to reach us.

If you believe that the Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Advocacy Department
Attn: Civil Rights Coordinator
PO Box 4717
Syracuse, NY 13221
Telephone number: 1-800-614-6575
TTY number: 1-800-421-1220
Fax: 1-315-671-6656

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Health Plan's Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 1-800-537-7697 (TDD)
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Attention: If you speak English free language help is available to you. Please refer to the enclosed document for ways to reach us.

Atención: Si habla español, contamos con ayuda gratuita de idiomas disponible para usted. Consulte el documento adjunto para ver las formas en que puede comunicarse con nosotros.

注意：如果您说中文，我们可为您提供免费的语言协助。
请参见随附的文件以获取我们的联系方式。

Внимание! Если ваш родной язык русский, вам могут быть предоставлены бесплатные переводческие услуги. В приложенном документе содержится информация о том, как ими воспользоваться.

Atansyon: Si ou pale Kreyòl Ayisyen gen èd gratis nan lang ki disponib pou ou. Tanpri gade dokiman ki nan anvlòp la pou jwenn fason pou kontakte nou.

주목해 주세요: 한국어를 사용하시는 경우, 무료 언어 지원을 받으실 수 있습니다. 연락 방법은 동봉된 문서를 참조하시기 바랍니다.

Attenzione: Se la vostra lingua parlata è l'italiano, potete usufruire di assistenza linguistica gratuita. Per sapere come ottenerla, consultate il documento allegato.

אויפמערקזאם: אויב איר רעדט אידיש, איז אומזיסטע שפראך הילף אוועילעבל פאר אייך ביטע רעפערירט צום בייגעלייגטן דאקומענט צו זען אופנים זיך צו פארבינדן מיט אונז.

নজর দিন: যদি আপনি বাংলা ভাষায় কথা বলেন তাহলে আপনার জন্য সহায়তা উপলভ্য রয়েছে। আমাদের সঙ্গে যোগাযোগ করার জন্য অনুগ্রহ করে সংযুক্ত নথি পড়ুন।

Uwaga: jeśli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Patrz załączony dokument w celu uzyskania informacji na temat sposobów kontaktu z nami.

تنبيه: إذا كنت تتحدث اللغة العربية، فإن المساعدة اللغوية المجانية متاحة لك. يرجى الرجوع إلى الوثيقة المرفقة لمعرفة كيفية الوصول إلينا.

Remarque : si vous parlez français, une assistance linguistique gratuite vous est proposée. Consultez le document ci-joint pour savoir comment nous joindre.

نوٹ: اگر آپ اردو بولتے ہیں تو آپ کے لیے زبان کی مفت مدد دستیاب ہے۔ ہم سے رابطہ کرنے کے طریقوں کے لیے منسلک دستاویز ملاحظہ کریں۔

Paunawa: Kung nagsasalita ka ng Tagalog, may maaari kang kuning libreng tulong sa wika. Mangyaring sumangguni sa nakalakip na dokumento para sa mga paraan ng pakikipag-ugnayan sa amin.

Προσοχή: Αν μιλάτε Ελληνικά μπορούμε να σας προσφέρουμε βοήθεια στη γλώσσα σας δωρεάν. Δείτε το έγγραφο που εσωκλείεται για πληροφορίες σχετικά με τους διαθέσιμους τρόπους επικοινωνίας μαζί μας.

Kujdes: Nëse flisni shqip, ju ofrohet ndihmë gjuhësore falas. Drejtojuni dokumentit bashkëlidhur për mënyra se si të na kontaktoni.

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