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

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)

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