2024 MEDICARE SUPPLEMENT/ MEDICARE SELECT PLAN
Application for Coverage with Health History

BlueCross BlueShield Minnesota

You may not need to complete the health history section if you qualify for a guaranteed issue. Please refer to the SPECIAL NOTES section for additional information. Medical underwriting is prohibited during periods of guaranteed issue and open enrollment. Minnesota does not allow post claim underwriting.

How to complete this application:

1. **You must have both Medicare Part A and Part B to qualify for this coverage. Please fill out this information when requested as it appears on your Medicare card. You can also attach a copy of your Medicare card or your letter from the Social Security or the Railroad Retirement Board (RRB).**
2. Please print and use a ball point pen in black or blue ink. Applications completed in pencil are not acceptable.
3. If you and your spouse both wish to apply, please complete separate applications.
4. **Please choose a payment method (section C) - All payment methods follow an annual calendar cycle.**
5. Please return this document by email to enrollment.forms@bluecrossmn.com or fax to (651) 662-6315. Applicants may also return this document in the envelope provided and mail to: Blue Cross and Blue Shield of Minnesota, P.O. Box 982807, El Paso, TX 79998-2807.
6. Please allow three to six weeks for your coverage to be set up. You will receive your Blue Cross member identification card after your application has been processed.
7. **If you are currently enrolled in a Medicare Supplement plan, you must follow the appropriate process to cancel it. Contact your plan for information on how to cancel the plan. If you are replacing a Medicare Supplement policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.**
8. For your plan selection, if your Medicare Part A eligibility date is on or after January 1, 2020, please complete section B1. If your Medicare Part A eligibility date is prior to January 1, 2020, please complete section B2.

This policy or certificate is expected to return on average an anticipated loss ratio of 65 percent of your premium dollar for health care. The lowest percentage permitted by state law for this policy or certificate is 65 percent.

Questions?

Call your licensed Blue Cross agent or one of our Medicare consultants. We are happy to help you.

(651) 662-2583 or toll free 1-877-662-2583 or TTY users call 711
8 a.m. to 8 p.m. daily Central Time. We are available seven days a week October 1 through March 31 and available Monday through Friday the rest of the year.

SPECIAL NOTES

- **GUARANTEED ISSUE** – Medicare Supplement and Medicare Select issuers must guarantee issue all policies to eligible individuals. This means that the insurer cannot discriminate in the pricing of such a policy because of health status, claims experience, receipt of care, medical condition, age, or impose an exclusion of benefits based upon a preexisting condition. If you are newly enrolling in Medicare, you may apply up to three (3) months prior to your Medicare effective date, the month of, and up to three (3) months after your Medicare effective date. If the effective date of this application is within six months of your Medicare Part B effective date, you have a seven-month open enrollment window during which time you are eligible for guaranteed issue. In addition, if you are currently enrolled in a Medicare Select, Medicare Supplement, Employer Retiree Plan, Medicare Advantage, Medicare Cost or Health Care Prepayment Plan and the contract is terminating, you may be eligible for guaranteed issue. You must apply for coverage within 63 calendar days of the date your coverage terminates and include a copy of that plan's termination letter. If your Medicare Advantage plan is terminating, your eligibility for guaranteed issue begins on the date you were notified of the termination. You must apply for coverage within 63 days of the date your coverage terminates.
- **MULTIPLE COVERAGE** – You do not need more than one Medicare Supplement/Medicare Select or Medicare Advantage/Medicare Cost policy or certificate. If you purchase this policy, you may want to evaluate your existing health care coverage and decide if you need multiple coverages.
- **DISABILITY** – If you are enrolled in Medicare because you are disabled and are covered under a group health plan through your employer, you may not need this Medicare Supplement or Select policy. The benefits and charges you receive under this Medicare Supplement or Select policy may be suspended during your enrollment in a group health plan. You must request this suspension in writing by contacting Blue Cross. When your group health plan coverage ends, your Medicare Supplement or Select policy will be reactivated if you request us to do so, in writing, within 90 days of your group plan coverage termination.
- **MEDICAL ASSISTANCE** – You may be eligible for benefits under Medical Assistance and may not need a Medicare Supplement/Medicare Select policy or certificate. The benefits and premiums under this Medicare Supplement/ Medicare Select contract can be suspended, if requested, for a total of 24 months during your entitlement to benefits under Medical Assistance. You must request this suspension in writing within 90 days of becoming eligible for Medical Assistance. If you are no longer entitled to Medical Assistance, this contract may be reinstated. However, you must request reinstatement in writing within 90 days of losing Medical Assistance.
- **COUNSELING SERVICES** – Insurance counseling services may be available in Minnesota to provide advice concerning Medical Assistance through state Medical Assistance, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs) through the Senior LinkAge Line at 1-800-333-2433.
- **RIGHT TO RETURN POLICY OR CERTIFICATE** – If you find that you are not satisfied with your policy or certificate for any reason, you may return it to Blue Cross and Blue Shield of Minnesota, P.O. Box 982807, El Paso, TX 79998-2807. If you send the policy back to us within 30 days after you receive it, we will treat the policy or certificate as if it had never been issued and return all of your payments within ten days.

A Enrollee information

Name Last First MI | **Gender** ☐ Male ☐ Female

Permanent Address (P.O. Box not allowed) Street City State ZIP

Phone Number | **Birthdate** | **County**

Mailing Address (P.O. Box is allowed) Street City State ZIP

Email Address

Please provide your Medicare insurance information.
You must have both Medicare Part A and Part B to qualify for this coverage.

Please take out your red, white and blue Medicare card to complete this section.

- Fill out this information as it appears on your Medicare card

- OR -

- Attach a copy of your Medicare card or your letter from Social Security or the Railroad Retirement Board (RRB)

Name (as it appears on your Medicare card):

_____

Medicare Number: _____

Is entitled to:	Effective Date (mm/dd/yyyy)
Hospital (Part A)	_____
Medical (Part B)	_____

B1 Available to members eligible for Medicare Part A on or after January 1, 2020. If your Medicare Part A eligibility date is prior to January 1, 2020, please complete section B2.

1a. Select only one plan:

☐ **Basic Medicare Supplement (Basic MedicareBlue℠)**, select from the options listed below:
- ☐ No riders
- ☐ Preventive care coverage rider
- ☐ Coverage of Medicare Part A inpatient hospital deductible rider
- ☐ Coverage of 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge

☐ **Basic Medicare Select (Senior Gold℠)**, select from the options listed below:
- ☐ No riders
- ☐ Preventive care coverage rider
- ☐ Coverage of Medicare Part A inpatient hospital deductible rider
- ☐ Coverage of 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge

☐ **Extended Basic Medicare Supplement (Extended Basic Blue®),** without coverage of Part B deductible
☐ **Extended Basic Medicare Select Supplement (Extended Basic Blue®),** without coverage of Part B deductible
☐ **Medicare Supplement Plan with High Deductible Plan (Plan F),** without coverage of Part B deductible
☐ **Medicare Supplement Plan with 50 Percent Coverage (Plan K)**
☐ **Medicare Supplement Plan with 75 Percent Coverage (Plan L)**
☐ **Medicare Supplement Plan with $20 and $50 co-payments (Plan N)**

B2 Available to members eligible for Medicare Part A prior to January 1, 2020. If your Medicare Part A eligibility date is on or after January 1, 2020, please complete section B1.

1b. Select only one plan:

☐ **Basic Medicare Supplement (Basic MedicareBlue℠),** select from the options listed below:
- ☐ No riders
- ☐ Preventive care coverage rider
- ☐ Coverage of Medicare Part A inpatient hospital deductible rider
- ☐ Coverage of Medicare Part B annual deductible rider
- ☐ Coverage of 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge

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☐ **Basic Medicare Select (Senior Gold℠),** select from the options listed below:
- ☐ No riders
- ☐ Preventive care coverage rider
- ☐ Coverage of Medicare Part A inpatient hospital deductible rider
- ☐ Coverage of Medicare Part B annual deductible rider
- ☐ Coverage of 100 percent of the Medicare Part B excess charges coverage for all of the difference between the actual Medicare Part B charges as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge

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☐ **Extended Basic Medicare Supplement (Extended Basic Blue®),** with coverage of Part B deductible
☐ **Extended Basic Medicare Supplement (Extended Basic Blue®),** without coverage of Part B deductible
☐ **Extended Basic Medicare Select Supplement (Extended Basic Blue®),** with coverage of Part B deductible
☐ **Extended Basic Medicare Select Supplement (Extended Basic Blue®),** without coverage of Part B deductible
☐ **Medicare Supplement Plan with High Deductible Plan (Plan F),** with coverage of Part B deductible
☐ **Medicare Supplement Plan with High Deductible Plan (Plan F),** without coverage of Part B deductible
☐ **Medicare Supplement Plan with 50 Percent Coverage (Plan K)**
☐ **Medicare Supplement Plan with 75 Percent Coverage (Plan L)**
☐ **Medicare Supplement Plan with $20 and $50 co-payments (Plan N)**

C Premium and payment information

1. Tobacco Use Designation and Declaration

I have used tobacco, smokeless tobacco, e-cigarettes, nicotine replacement products, or vaping products during the 24 months immediately preceding the date of this application. ☐ **Yes** ☐ **No**

Please note that your rates may be increased if you indicate that you do not use tobacco as of the effective date of this application and evidence to the contrary is later discovered. If you are tobacco-free for a period of 24 consecutive months after your effective date, you must notify Blue Cross, in writing, so that your rate can be decreased.

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2. Amount paid with this application (payment of first month's premium is not required at time of application)

$ _____

Payment options Get a Bill: ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

- **New members in Medicare Supplement will receive their first invoice by mail with instructions about automatic payment options.**
- **Members changing Medicare Supplement plans will keep their existing automatic payment arrangement. To cancel an automatic payment arrangement or change the payment frequency, please call the customer service number on the back of your member ID card.**

D Coverage determination and other coverage information

Please answer these questions to the best of your knowledge.

1. Are you applying for coverage within 6 months of your 65th birthday? If **YES**, you qualify for guaranteed issue. You do not need to fill out Section E Health History or answer questions 2 and 3.	☐ **Yes** ☐ **No**
2. Are you applying for coverage within 6 months of receiving your Medicare Part B benefits? If **YES**, you qualify for guaranteed issue. You do not need to fill out Section E Health History or answer question 3.	☐ **Yes** ☐ **No**
3. Are you being terminated from a Medicare Supplement/Medicare Select, Employer or Retiree Plan, Medicare Advantage, Medicare Cost or Health Care Prepayment Plan? If **YES**, you may be eligible for the guaranteed issuance of a Medicare Select or Supplement contract. Please include a copy of your current plan's termination letter and read the **SPECIAL NOTES** section.	☐ **Yes** ☐ **No**
Are you applying for coverage within 63 days of receiving your termination letter for the above coverage? If **NO**, you do not qualify for guaranteed issue and will need to fill out Section E Health History.	☐ **Yes** ☐ **No**
a. Trial Rights - You were enrolled under a Medicare Supplement contract and you terminate coverage to enroll for the first time in a Medicare Advantage, Medicare Cost, Health Care Prepayment Plan, or Medicare Select Plan, and then you disenrolled from that plan within the first 12 months. If you are eligible, you are entitled to the same Medicare Supplement contract in which you were most recently enrolled, if available, from the same issuer. If the contract is not available, you are entitled to a Basic Medicare Supplement or Select contract offered by any issuer. **OR** After first enrolling in Medicare Part B, you enrolled in a Medicare Advantage Plan or Medicare Cost Plan and then disenrolled from that plan within 12 months. If you are eligible, you are entitled to any Medicare Supplement or Select contract offered by any issuer Do either of these scenarios apply to you? If **YES**, you qualify for guaranteed issue. Do not fill out Section E Health History.	☐ **Yes** ☐ **No**
4. Has an agent sold to you any other health insurance policies? Are these policies still in force? List policies sold that are still in force_____ List policies sold in the past five years that are no longer in force_____ _____	☐ **Yes** ☐ **No** ☐ **Yes** ☐ **No**
a. Do you have another Medicare supplement policy or certificate in force? If **YES**, with which company? Please fill out information below.	☐ **Yes** ☐ **No**
If **YES**, do you intend to replace your current Medicare supplement policy with this policy or certificate?	☐ **Yes** ☐ **No**
Do you have any other health insurance policies that provide benefits which this Medicare Supplement policy or Certificate would duplicate? If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new policy or certificate and are sure you want to keep it.	☐ **Yes** ☐ **No**

b. If you answered **YES** to questions 3 or 4, please provide us with the following information about your current plan:

Company (Carrier) Name:_____

Type of Policy:_____ Policy Number:_____

(Medicare Supplement / Medicare Advantage / Medicare Cost / Employee or Retiree Plan / VA / TRICARE)

Policy Effective Date:_____ *Policy Termination Date:_____

***Note** – We will not terminate any other plan based on filling in this termination date.

If the above information is missing or incomplete, you may be required to provide the information or a copy of your plan coverage term letter.

5. Are you covered for Medical Assistance through the state Medicaid program? ☐ **Yes** ☐ **No**

If **YES**, which of the following programs provides coverage for you?

- ☐ Qualified Medicare Beneficiary (QMB)
- ☐ Full Medicaid Beneficiary
- ☐ Specified Low-Income Medicare Beneficiary (SLMB)

E Health history

DO NOT ANSWER THESE HEALTH QUESTIONS IF YOU ARE APPLYING DURING OPEN ENROLLMENT OR A GUARANTEED ISSUE PERIOD. Medical underwriting is prohibited during periods of guaranteed issue and open enrollment. Minnesota does not allow post claim underwriting. See **SPECIAL NOTES** section. You do not need to complete the following health history questions if you are eligible for guaranteed issue (including the seven month open enrollment window following your Part B effective date).

You do not have to disclose a test to detect the presence of hepatitis B virus (HBV), hepatitis C virus (HCV), human immunodeficiency virus (HIV), or other blood borne pathogens which was administered to you at the time you were:

a. A criminal offender or crime victim as a result of a crime that was reported to the police
b. An emergency medical professional who was tested as a result of performing emergency medical services
c. A corrections employee
d. A patient or employee of a secured facility

1. Are you currently:

a. Confined to a bed? ☐ **Yes** ☐ **No**
b. Residing in a nursing facility or other health care facility? ☐ **Yes** ☐ **No**
c. Needing assistance of a wheelchair or any other mobility device? ☐ **Yes** ☐ **No**
d. Needing home health care assistance? ☐ **Yes** ☐ **No**

Checking **YES** to any question in number 1 does not meet our eligibility criteria and we are unable to offer you this plan.

E Health history – continued

2. Have you been diagnosed or treated with any of the below conditions within the past 5 years? ☐ **Yes** ☐ **No**

Checking **YES** to question 2 does not meet our eligibility criteria and we are unable to offer you this plan.

Blood Diseases/Hematology
- Blood disorder (including clotting diseases and Myelodysplastic Syndrome)
- Bone Marrow Transplant

Cancer
- Cancer (except for non-melanoma skin cancer)

Endocrine Disorders
- Diabetes (any type)

Gastrointestinal and Liver
- Cirrhosis of Liver
- Crohn's Disease
- Ulcerative Colitis

Heart and Vascular Diseases
- Atrial Fibrillation or Flutter
- Carotid Artery Disease
- Cardiomyopathy
- Coronary Artery Disease
- Congestive Heart Failure
- Heart Attack
- Heart Valve Disorder
- Peripheral Vascular Disease
- Ventricular Arrhythmias

Kidney Disease
- Chronic kidney failure- Stage 3 or greater
- End Stage Renal Disease (ESRD) on chronic dialysis
- Polycystic Kidney Disease (PKD)

Mental Health
- Bipolar Disease
- Schizophrenia
- Substance Use Disorder (Drug and Alcohol)

Nervous System
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Multiple Sclerosis
- Parkinson's Disease

Other
- Organ transplant (other than cornea)
- Wet Macular Degeneration (untreated or currently under treatment)

Respiratory System
- Chronic oxygen dependence
- COPD (Chronic Obstructive Pulmonary Disease)/ Emphysema
- Pulmonary Fibrosis

Systemic Diseases
- Autoimmune Diseases (excludes Hashimoto's Disease)
- Myasthenia Gravis
- Rheumatoid Arthritis
- Systemic Lupus Erythematosus

3. Other than the conditions listed above, within the past 5 years, have you been treated or diagnosed with any other condition, advised to have surgery, or been hospitalized two or more times? ☐ **Yes** ☐ **No**

If **YES**, please specify: _____

4. During the past 12 months, have you either taken a prescription drug or had a drug prescribed by your health provider? ☐ **Yes** ☐ **No**

If **YES**, please specify: _____

5. Height _____ Weight _____

F Authorization and acknowledgments

I acknowledge receipt of the following information (If **NO**, please contact your agent. If you do not have an agent, please go to bluecrossmn.com):

- Summary of Coverage and Disclosure of Information ☐ **Yes** ☐ **No**
- Choosing a Medigap Policy ☐ **Yes** ☐ **No**

I have read this entire application, and I represent all information, statements, and answers herein to be true and complete to the best of my knowledge and belief. I also understand and agree that:

(a) coverage, if issued, will be issued in full reliance on this application and that any untrue or incomplete information, statements, or answers in this application which materially affect either the acceptance of risk or hazard assumed by Blue Cross can result in denial of a claim, or recision of coverage. I agree to notify Blue Cross of any change in my health condition between the date of this application and the effective date of coverage. Failure to notify Blue Cross of any change in my health condition can result in denial of a claim or recision of coverage; and,

(b) for administrative convenience, Blue Cross may deposit in bank any cash or check I submit with this application, but such deposit shall not constitute an approval of this application or issuance of coverage.

Under Minnesota law, your agent is obligated to make reasonable inquiries of you to determine which, if any, of the Blue Cross and Blue Shield of Minnesota (Blue Cross) plans is suitable for your needs. You may also want to talk with a family member or friend about your selection. If you are thinking of keeping your current coverage, discuss the rates and benefits of that plan in comparison to the new Blue Cross product you are choosing. Remember, if you want to increase your benefits in the future, your eligibility may be determined by your medical history and health status at that time. Consider the following before you choose one of our Medicare Supplement or Medicare Select products.

1. You do not need more than one Medicare Supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can 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 (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 the suspension. Upon reinstitution of your Medicare Supplement policy there is no waiting period with respect to treatment of pre-existing conditions; benefits will be substantially the same as benefits in effect before the date of such suspension; and the premium classification terms will be at least as favorable as the premium terms that would have applied had your policy not been suspended.
5. 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 suspension.
6. 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).

F Authorization and acknowledgments – continued

By the signature below, I hereby authorize and request any hospital, clinic, institution, physician, or other person to furnish Blue Cross full details of diagnosis, treatment, medical history, and any other information and conclusions about me and to accept as valid a photocopy of this authorization and my signature. Blue Cross needs this information to process claims, conduct utilization review and quality improvement activities, and for other health plan activities as permitted by law. Blue Cross keep this information confidential, but may release it if I authorize release, or if state or federal law permits or requires release without authorization. For claims purposes, this authorization is valid while I am enrolled in this health plan and until all claims are adjudicated following my termination of coverage. If the authorization is signed to collect information in connection with an application for a life, disability, and health insurance policy or contract, reinstatement, or request for change in benefits, the authorization is valid as long as I am continually insured with the insurer. At each renewal of the policy, the insurer must notify me in writing of the contents of the authorization and that the authorization remains in effect unless revoked. This authorization excludes the release of information related (HIV), or other bloodborne pathogens, if such tests were administered to me at the time I was: (a) a criminal offender or crime victim as a result of a crime that was reported to police; (b) an emergency medical professional who was tested as a result of performing emergency medical services; (c) a corrections employee; or (d) a patient or employee of a secured facility. I also verify that I have read the terms listed in the SPECIAL NOTES section of this application.

It is not a material misrepresentation for purposes of rescission or cancellation of the policy to omit answers to medical and health history questions on the application during open enrollment and guaranteed issue periods. The policy must guarantee renewability and cannot be canceled or nonrenewed on the grounds of the deterioration of health of the insured or for any reason other than nonpayment of premium subject to the grace period or material misrepresentation.

I agree that, if approved, coverage will be effective on the first day of the month following approval or on the date designated here, provided it is not prior to the date this application was received at Blue Cross and is not more than 90 days beyond the date this application is signed.

Medical underwriting is prohibited during periods of guaranteed issue and open enrollment. Minnesota does not allow post claim underwriting.

Requested Effective Date: _____

Signature: _____ **Date:** _____

☐ I authorize my licensed agent, identified below, to enter and submit my application information online to Blue Cross electronically.

If you are the authorized representative, you must sign above and provide the following information:

Name: _____

Address: _____

Phone Number: (_____ **)**_____ **Relationship to Enrollee:** _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE

Blue Cross and Blue Shield of Minnesota 3400 Yankee Drive Eagan, MN 55121.

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE. According to your application, you intend to terminate existing Medicare supplement insurance and replace it with a policy or certificate to be issued by Blue Cross Blue Shield of Minnesota Insurance Company. Your new policy or certificate will provide 30 days within which you may decide without cost whether you desire to keep the policy or certificate. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision you should terminate your present Medicare supplement policy You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

F Authorization and acknowledgments – continued

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, the policy will not duplicate your existing Medicare Supplement policy because you intend to terminate the existing Medicare Supplement policy.

The replacement policy or certificate is being purchased for the following reason (check one):

☐ Additional benefits ☐ Fewer benefits and lower premiums ☐ No change in benefits, but lower premiums
☐ Other (specify):_____

(1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy or certificate. This could result in denial or delay of a claim for benefits under the new policy or certificate, whereas a similar claim might have been payable under your present policy or certificate.

(2) State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods, or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent the time was spent (depleted) under the original policy or certificate.

(3) If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy or certificate had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy or certificate until you have received your new policy or certificate and you are sure that you want to keep it.

I have discussed the suitability of the proposed coverage with my client and have considered the totality of the applicant's circumstances.

_____
Signature of Agent, Broker, or Other Representative

_____ _____
Typed Name and Address of Issuer, Agent, or Broker Date

_____ _____
Applicant Signature Date

If an agent has recorded the responses given by the applicant, please sign below. (If an agent has assisted with this application, agent shall list any other health insurance policies they have sold to the applicant.)

Agency Code: _____ **Producer Number:** _____

Producer Name: _____

Producer Signature: _____

Date: _____ **Daytime Phone Number: (** _____ **)** _____

Notice Concerning Policyholder Rights in an Insolvency Under the Minnesota Life and Health Insurance Guaranty Association Law

If the insurer or health maintenance organization that issued your life, annuity, or health insurance policy becomes impaired or insolvent, you are entitled to compensation for your policy from the assets of that insurer. The amount you recover will depend on the financial condition of the insurer or health maintenance organization.

In addition, residents of Minnesota who purchase life insurance, annuities, health insurance from insurance companies authorized to do business in Minnesota are protected, SUBJECT TO LIMITATIONS AND EXCLUSIONS, in the event the insurer or health maintenance organization becomes financially impaired or insolvent. This protection is provided by the Minnesota Life and Health Insurance Guaranty Association.

Minnesota Life & Health Insurance Guaranty Association 3300 Wells Fargo Center 90 S. 7th St. Minneapolis, MN 55402	Phone: (612) 322-8713 Fax: (308) 635-1020 Email Address: info@mnlifega.org Website: mnlifega.org/

The maximum amount the Guaranty Association will pay for all policies issued by the same insurer or health maintenance organization is limited to $500,000 limit, the Guaranty Association will pay up to $500,000 in life insurance death benefits, $130,000 in net cash surrender and net cash withdrawal values for life insurance, $500,000 in health insurance health maintenance organization, and long-term care benefits, including any net cash surrender and net cash withdrawal values, $500,000 in disability income insurance, $250,000 in annuity net cash surrender and net cash withdrawal values, $410,000 in present value of annuity benefits for annuities which are part of a structured settlement or for annuities inregard to which periodic annuity benefits, for a period not less than the annuitant's lifetime or for a period certain of not less than 10 years, have begun to be paid on or before the date of impairrment or insolvency, or if no coverage limit has been specified for a covered policy or benefit, the coverage limit shall be $500,000 in present value. Unallocated annuity contracts issued to retirement plans, other than defined benefit plans, established under section 401, 403(b), or 457 of the Internal Revenue Code of 1986, as amended through December 31, 1992, are covered up to $250,000 in net cash surrender and net cash withdrawal values, for Minnesota residents covered by the plan provided, however, that the Association shall not be responsible for more than $10,000,000 in claims from all Minnesota residents covered by the plan. If total claims exceed $10,000,000, the $10,000,000 shall be prorated among all claimants. These are the maximum claimant amounts. Coverage by the Guaranty Association is also subject to other substantial limitations and exclusions and requires continued residency in Minnesota. If your claim exceeds the Guaranty Association's lmits, you may still recover a part or all of that $250,000 amount from the proceeds of the liquidation of the insolvent insurer, if any exist.

Funds to pay claims may not be immediately available. The Guaranty Association assesses insurers and health maintenance organizations licensed to sell life and health insurance in Minnesota after the insolvency occurs. Claims are paid from this assessment. Benefits provided by a long-term care rider to a life insurance policy or annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

THE COVERAGE PROVIDED BY THE GUARANTY ASSOCIATION IS NOT A SUBSTITUTE FOR USING CARE IN SELECTING INSURANCE COMPANIES THAT ARE WELL MANAGED AND FINANCIALLY STABLE. IN SELECTING AN INSURANCE COMPANY, CONTRACT OR POLICY, YOU SHOULD NOT RELY ON COVERAGE BY THE GUARANTY ASSOCIATION.

THIS NOTICE IS REQUIRED BY MINNESOTA STATE LAW TO ADVISE POLICYHOLDERS OF LIFE, ANNUITY, OR HEALTH INSURANCE, OR HEALTH INSURANCE ORGANIZATION POLICIES AND CONTRACTS OF THEIR RIGHTS IN THE EVENT THEIR INSURANCE CARRIER BECOMES FINANCIALLY INSOLVENT. THIS NOTICE IN NO WAY IMPLIES THAT THE COMPANY CURRENTLY HAS ANY TYPE OF FINANCIAL PROBLEMS. ALL LIFE, ANNUITY, AND HEALTH INSURANCE AND HEALTH MAINTENANCE HEALTH ORGANIZATION POLICIES AND CONTRACTS ARE REQUIRED TO PROVIDE THIS NOTICE.

NOTICE OF NONDISCRIMINATION PRACTICES

Effective July 18, 2016

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or gender. Blue Cross does not exclude people or treat them differently because of race, color, national origin, age, disability, or gender.

Blue Cross provides resources to access information in alternative formats and languages:

- Auxiliary aids and services, such as qualified interpreters and written information available in other formats, are available free of charge to people with disabilities to assist in communicating with us.
- Language services, such as qualified interpreters and information written in other languages, are available free of charge to people whose primary language is not English.

If you need these services, contact us at 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711.

If you believe that Blue Cross has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or gender, you can file a grievance with the Nondiscrimination Civil Rights Coordinator

- by email at: Civil.Rights.Coord@bluecrossmn.com
- by mail at: Nondiscrimination Civil Rights Coordinator
  Blue Cross and Blue Shield of Minnesota and Blue Plus
  M495
  PO Box 64560
  Eagan, MN 55164-0560
- or by phone at: 1-800-509-5312

Grievance forms are available by contacting us at the contacts listed above, by calling 1-800-382-2000 or by using the telephone number on the back of your member identification card. TTY users call 711. If you need help filing a grievance, assistance is available by contacting us at the numbers listed above.

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
- by phone at:
  1-800-368-1019 or 1-800-537-7697 (TDD)
- or by mail at:
  U.S. Department of Health and Human Services
  200 Independence Avenue SW
  Room 509F
  HHH Building
  Washington, DC 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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This information is available in other languages. Free language assistance services are available by calling the toll free number below. For TTY, call 711.

Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al 1-855-903-2583. Para TTY, llame al 711.

Yog tias koj hais lus Hmoob, muaj kev pab txhais lus pub dawb rau koj. Hu rau 1-800-793-6931. Rau TTY, hu rau 711.

Haddii aad ku hadasho Soomaali, adigu waxaad heli kartaa caawimo luqad lacag la'aan ah. Wac 1-866-251-6736. Markay tahay dad maqalku ku adag yahay (TTY), wac 711.

နမ့်ကတိၤကညီကျိာ်ဒီး, တ်ကဟ့ဉ်နၤကျိာ်တ်မၤစၢၤကလိတဖဉ်နူဉ်လိၤ. ကိး 1-866-251-6744 လၢ TTY အဂိၢ်, ကိး 711 တကှ်.

إذا كنت تتحدث العربية، تتوفر لك خدمات المساعدة اللغوية المجانية. اتصل بالرقم 1-866-569-9123. للهاتف النصي اتصل بالرقم 711.

Nếu quý vị nói Tiếng Việt, có sẵn các dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Gọi số 1-855-315-4015. Người dùng TTY xin gọi 711.

Afaan Oromoo dubbattu yoo ta’e, tajaajila gargaarsa afaan hiikuu kaffaltii malee. Argachuuf 1-855-315-4016 bilbilaa. TTY dhaaf, 711 bilbilaa.

如果您說中文，我們可以為您提供免費的語言協助服務。請撥打 1-855-315-4017。聽語障專 (TTY)，請撥打 711。

Если Вы говорите по-русски, Вы можете воспользоваться бесплатными услугами переводчика. Звоните 1-855-315-4028. Для использования телефонного аппарата с текстовым выходом звоните 711.

Si vous parlez français, des services d’assistance linguistique sont disponibles gratuitement. Appelez le +1-855-315-4029. Pour les personnes malentendantes, appelez le 711.

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한국어를 사용하시는 경우, 무료 언어 지원 서비스가 제공됩니다. 1-855-904-2583 으로 전화하십시오. TTY 사용자는 711 로 전화하십시오.

ຖ້າເຈົ້າເວົ້າພາສາລາວໄດ້, ມີການບໍລິການຊ່ວຍເຫຼືອພາສາໃຫ້ເຈົ້າຟຣີ. ໃຫ້ໂທຫາ 1-866-356-2423 ສຳລັບ. TTY, ໃຫ້ໂທຫາ 711.

Kung nagsasalita kayo ng Tagalog, mayroon kayong magagamit na libreng tulong na mga serbisyo sa wika. Tumawag sa 1-866-537-7720. Para sa TTY, tumawag sa 711.

Wenn Sie Deutsch sprechen, steht Ihnen fremdsprachliche Unterstützung zur Verfügung. Wählen Sie 1-866-289-7402. Für TTY wählen Sie 711.

ប្រសិនបើអ្នកនិយាយភាសាខ្មែរមន អ្នកអាចរកបានសេវាជំនួយភាសាឥតគិតថ្លៃ។ ទូរស័ព្ទមកលេខ 1-855-906-2583។ សម្រាប់ TTY សូមទូរស័ព្ទមកលេខ 711។

Diné k'ehjí yáníłt'i'go saad bee yát'i' éí t'áájíík'e bee níká'a'doowołgo éí ná'ahoot'i'. Kojį éí béésh bee hodíílnih 1-855-902-2583. TTY biniiyégo éí 711 jį’ béésh bee hodíílnih.

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