

How to apply for a Blue Cross® Blue Shield® of Arizona Medicare Supplement Plan



Thank you for selecting Blue Cross® Blue Shield® of Arizona (AZ Blue). If you have questions, need assistance completing the application, or need additional application forms, please call your health insurance producer or AZ Blue at **1-888-264-1733, TTY: 711**. Hours are Monday-Friday, 8am to 5pm.

You are eligible to apply if:

- In general, you are 65 years* of age or older; and
- You are enrolled in Medicare Parts A and B; and
- You reside in Arizona, if you are applying for Senior SecuritySM; or
- You reside in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, or Santa Cruz County, if you are applying for Senior PreferredSM.

You are *not* eligible to apply for an AZ Blue Medicare Supplement plan if:

- You are receiving disability benefits and are under age 65.
- You are not a resident of Arizona.
- You already have a Medicare Supplement or Medicare Advantage policy and do not intend to replace it with this plan.
- **You meet any of the conditions below, unless you are entitled to Guaranteed Issue rights**, as described in the CMS brochure, "Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare," which AZ Blue makes available with this application. You may contact the State Health Insurance Assistance Program at **602-542-6595, 1-800-432-4040** Statewide, or TTY Line at **602-542-6366** for information regarding plans that may be available to you if you have end-stage renal disease.
 - You are receiving or have been advised to receive kidney dialysis.
 - **You have end-stage renal disease (ESRD).**
 - You have been diagnosed with a kidney disease that may require kidney dialysis.
 - You have had an inpatient admission into a hospital within the last 90 days.
 - You are currently in the process of a medical work-up or treatment for an unresolved condition related to any of the following:
 - Organ transplant, back or spine surgery, joint replacement, surgery for cancer, heart surgery, vascular surgery.

Here's how to apply: *Please use dark ink. (Do not use red ink.)*

1. Complete, sign, and date all sections as indicated by signature boxes.
2. If you are applying for Senior Preferred Medicare Select coverage, please read the Senior Preferred subsection in the Acknowledgements.
3. If you would like the convenience of automatic withdrawal for billing purposes, be sure to complete, sign, and date the Autopay Authorization Form.
4. If you would like AZ Blue to share your personal information with another individual (such as a spouse, child, or producer), please read the instructions and complete the Confidential Information Release Form included as part of this application. **This is an optional form.**
5. Mail the entire application form to:
AZ Blue ATTN: Enrollment
P.O. Box 13466
Phoenix, AZ 85002-3466

We will return a copy to you. **Do not send any premium.** (If your application is approved, you will be billed when a contract is issued to you.)

*You may apply during the time period when you are enrolled in Medicare Parts A and B and you are age 64, if there are no more than 90 days until the first day of the month in which you turn 65.

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Application for Medicare Supplement Coverage



1. Your Choice of Coverage

Senior Security Available throughout Arizona Plan: <input type="checkbox"/> A <input type="checkbox"/> C [†] <input type="checkbox"/> D <input type="checkbox"/> F [†] <input type="checkbox"/> G <input type="checkbox"/> N	Senior Preferred (Medicare Select) Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, and Santa Cruz counties Plan: <input type="checkbox"/> C [†] <input type="checkbox"/> D <input type="checkbox"/> G <input type="checkbox"/> N
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Your Desired Effective Date					
1st day of (month)					
<input type="checkbox"/> Jan	<input type="checkbox"/> Mar	<input type="checkbox"/> May	<input type="checkbox"/> July	<input type="checkbox"/> Sept	<input type="checkbox"/> Nov
<input type="checkbox"/> Feb	<input type="checkbox"/> April	<input type="checkbox"/> June	<input type="checkbox"/> Aug	<input type="checkbox"/> Oct	<input type="checkbox"/> Dec

2. Applicant Information

Name (First/Middle Initial/Last)		
Are you an Arizona resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Physical Address		
City	State	ZIP
Mailing Address (if different from Physical Address)		
City	State	ZIP
Home Number	Mobile Number	Email address*
Date of Birth (MM/DD/YYYY) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	*By providing your email and mobile in this application, you agree to receive communications electronically via email or text from AZ Blue.
Do you currently have AZ Blue coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, who provides your coverage?		
Contract Holder's Name	AZ Blue Identification No.	
Have you used tobacco products in the past 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Medicare Number and Effective Dates. Please copy this information exactly as it appears on your Medicare Card.		
Medicare Number	Part A (Hospital) Coverage Starts (MM/DD/YYYY) / /	Part B (Medical) Coverage Starts (MM/DD/YYYY) / /

[†]Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

3. Eligibility & Prior Coverage 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 policy, or that you had certain rights to buy such a policy, 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 to the best of your knowledge.

- I. (a)** Did you turn age 65 in the last 6 months **OR** will you turn 65 in the next 90 days? **Yes** **No**
- (b)** Did you enroll in Medicare Part B in the last 6 months? **Yes** **No**
- (c)** If yes, what is the effective date (MM/DD/YYYY)? _____ / _____ / _____

- II. (a)** Are you covered for medical assistance through a 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.) **Yes** **No**
- (b)** If yes, will Medicaid pay your premiums for this Medicare Supplement policy? **Yes** **No**
- (c)** Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? **Yes** **No**

- III. (a)** Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, Medicare Advantage or Medicare HMO or PPO)? **Yes** **No**

If yes, fill in your start and end dates below. If you are still covered under this plan, leave “END” blank.

START _____ / _____ / _____ END _____ / _____ / _____
(M M / D D / Y Y Y Y Y) (M M / D D / Y Y Y Y Y)

- (b)** Please indicate the reason for terminating the Medicare policy (select one):
- I moved out of the service area
 - The plan stopped participating in Medicare or is no longer offered where I live
 - Other
- (c)** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy**? **Yes** **No**
- (d)** Was this your first time in this type of Medicare plan? **Yes** **No**
- (e)** Did you drop a Medicare Supplement policy to enroll in the Medicare plan? **Yes** **No**

IV. (a) Do you have another Medicare Supplement policy in force? **Yes** **No**

(b) If so, with what company? _____

What plan do you have? _____

(c) If so, do you intend to replace your current Medicare Supplement policy with this new Medicare Supplement policy**? **Yes** **No**

(d) Have you lost coverage from another Medicare Supplement policy within the last 63 days? .. **Yes** **No**

End Date ____/____/_____
(M M / D D / Y Y Y Y)

If yes, please indicate the reason for terminating the Medicare Supplement policy (select one):

- I moved out of the service area
- The plan stopped participating in Medicare or is no longer offered where I live
- Other

****If you answered Yes to questions III(c) or IV(c) and an agent is assisting you in purchasing this plan, be sure that your agent provides you with a completed Notice to Applicant form, located at the end of this application.**

V. (a) Have you had coverage under any other health insurance within the past 63 days? (for example, an employer group, union, or individual non-Medicare plan)? **Yes** **No**

(b) If so, with what company? _____

Carrier customer service # _____

By providing this # you authorize AZ Blue to contact your prior carrier to verify eligibility/prior coverage.

What type of policy do you have? _____

(c) What are your dates of coverage under the other policy? If you are still covered under the other policy, leave "END" blank.

START ____/____/_____ END ____/____/_____
(M M / D D / Y Y Y Y) (M M / D D / Y Y Y Y)

(d) Do you intend to replace this insurance with a new Medicare Supplement policy? **Yes** **No**

4. Medical Questions

If you answered Yes to questions I (a) or (b) in section 3 above (“Eligibility & Prior Coverage Information”), you are in your Open Enrollment Period and qualify for guaranteed acceptance. Please skip this section.

Please answer all questions below by marking Yes or No.

1. Have you been diagnosed with ESRD, or any other kidney disease that may require kidney dialysis? **Yes** **No**
2. Have you had an inpatient admission to a hospital within the last 90 days? **Yes** **No**
3. Are you currently in the process of a medical work-up or treatment for an unresolved condition related to any of the following?
 - a. Organ Transplant **Yes** **No**
 - b. Back or Spine Surgery **Yes** **No**
 - c. Joint Replacement **Yes** **No**
 - d. Surgery for Cancer **Yes** **No**
 - e. Heart Surgery **Yes** **No**
 - f. Vascular Surgery **Yes** **No**

If you answered yes to any of the questions above, you are NOT eligible for these plans at this time.

If your health status changes in the future, allowing you to answer No to all the questions in this section, please submit an application at that time.

4. Have you been in a skilled nursing facility, long-term care facility, rehabilitation facility, or nursing home within the last 2 years? **Yes** **No**
5. Have you been advised within the last 2 years to have any type of surgery that is planned, scheduled, or pending? **Yes** **No**
6. **Within the past 2 years, have you been diagnosed or treated for any of the following conditions, as determined by a medical professional? If you are unsure, please consult your physician.**
 - a. Cancer or tumors (other than skin cancer)..... **Yes** **No**
 - b. Alcoholism or substance abuse requiring inpatient or outpatient treatment..... **Yes** **No**
 - c. Psychological or mental health disorder(s) including hospitalization(s)..... **Yes** **No**
 - d. AIDS (Acquired Immune Deficiency Syndrome) or AIDS-related conditions or tested positive for the presence of antibodies to the AIDS virus (HIV)..... **Yes** **No**
 - e. Alzheimer’s disease, dementia, or cognitive impairment **Yes** **No**
 - f. Rheumatoid arthritis, myasthenia gravis, systemic lupus erythematosus (SLE), multiple sclerosis, amyotrophic lateral sclerosis (ALS)..... **Yes** **No**
 - g. Diabetes with any of the following: circulatory problems, kidney problems, or retinopathy.... **Yes** **No**
 - h. Emphysema, chronic obstructive pulmonary disease (COPD), or tuberculosis, (not including asthma)..... **Yes** **No**
 - i. Cirrhosis, hepatitis B, or hepatitis C **Yes** **No**
 - j. Parkinson’s disease..... **Yes** **No**
 - k. Osteoporosis with osteoporosis-related fractures..... **Yes** **No**
 - l. Degenerative bone disease **Yes** **No**

- m. Congestive heart failure (CHF), cardiomyopathy, carotid artery disease (CAD), peripheral vascular disease (PVD), aneurysm, arteriosclerosis or atherosclerosis, or artery or vein blockage Yes No
- n. Heart attack or stroke (including TIA); cardiac surgery (including coronary bypass surgery or angioplasty); rhythm disorders requiring a pacemaker; atrial fibrillation or atrial flutter; or ventricular tachycardia Yes No
- o. Chronic pancreatitis Yes No
- p. Esophageal varices Yes No
- q. Amputation due to disease Yes No
- r. Spinal stenosis Yes No
- s. Paraplegia, quadriplegia, or hemiplegia Yes No
- t. Macular degeneration Yes No

5. Important Information for Your Protection

- I. You do not need more than one Medicare Supplement policy.
- II. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- III. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- IV. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your AZ Blue 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- V. 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- VI. Counseling services may be available in Arizona to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits such as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

6. Acknowledgements—read this section and sign at the end

- I. I have carefully read all of this application form and the information I provided. I understand and agree that it will be part of my contract with AZ Blue.
- II. I understand and agree that:
- The information I've provided is material to AZ Blue's decision to offer healthcare coverage.
 - AZ Blue will rely on the accuracy of the information to determine my eligibility for coverage and the premium rate I will pay for that coverage.
 - If AZ Blue discovers a material misrepresentation or omission after issuing coverage, AZ Blue may rescind the contract and declare it null and void as of the effective date of coverage, or adjust my premium rate to the rate I should have paid based on accurate information, retroactive to the effective date of coverage.
 - Coverage will be effective only after AZ Blue has accepted and reviewed this application and assigned an effective date.
 - Coverage will be subject to the benefits, limitations, and provisions of the AZ Blue benefit plan, regardless of any other coverage I may have had in the past.
- III. I acknowledge that I have received an Outline of Coverage for AZ Blue's Senior Security and Senior Preferred plans.
- IV. I acknowledge that I have received a copy of the "Guide to Health Insurance for People with Medicare."
- V. I understand that:
- AZ Blue sells health and dental coverage products either directly or through independent licensed insurance producers.
 - Commission payments to producers are one of the costs factored into premiums, but AZ Blue's premium calculation is not based on whether a product is sold directly or by a producer.
 - AZ Blue generally pays a commission to the producer of record or permitted assignee until this contract is terminated or the contract holder terminates his/her relationship with the producer or the producer becomes ineligible.

VI. Medicare Select Acknowledgment

If you are enrolling in a Senior Preferred Medicare Select Plan, you acknowledge that you have received the following information and understand the restrictions of the Senior Preferred benefit plan:

- An Outline of Coverage comparing the Senior Preferred Medicare Select benefit plan and premium with the Senior Security benefit plans and premiums, which includes the following:
 - A description of benefits available when Senior Preferred or non-Senior Preferred providers are used
 - A description of coverage for emergency and out-of-service-area care
 - A description of limitations on referrals to non-Senior Preferred providers
 - A description of my right to purchase a Senior Security plan
 - A description of AZ Blue's quality assurance program and complaint and grievance procedure
- A Senior Preferred provider directory

VII. I give permission for AZ Blue to call me at the phone number(s) provided in this application to provide information and/or discuss matters related to any benefit plan that I purchase, as well as health and wellness information that is related to any such benefit plan.

All applicants must sign and date the signature box below to indicate agreement with the acknowledgments.

Applicant's Signature _____	Date _____ / _____ / _____ (M M / D D / Y Y Y Y)
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7. To be completed by the producer:

Producers shall list any other health insurance policies sold to the applicant.

I. Have you sold any other health insurance policies to the applicant, either in force or within the last five (5) years? **Yes** **No**

II. If Yes, list all health insurance policies sold to the applicant that are still in force.

III. List all health insurance policies sold to this applicant in the past five years that are no longer in force.

Producer's Signature _____	Date _____ / _____ / _____ (M M / D D / Y Y Y Y)
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SPACE BELOW FOR PRODUCER USE ONLY

PRODUCER NAME, MAILING ADDRESS, AND PHONE	NATIONAL PRODUCER NUMBER

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MEDICARE SUPPLEMENT AGREEMENT FOR AUTOMATIC DEPOSITS

Electronic Funds Transfer (EFT) or Automated Clearinghouse (ACH) Authorization



An Independent Licensee of the Blue Cross Blue Shield Association

Save the hassle of writing us a check. Pay your premiums the convenient way with Autopay! With Autopay, there's no bill to keep track of. No check to write. And nothing to mail (or forget to mail). Instead, your premium is automatically withdrawn from your checking or savings account. Just complete and sign this authorization form. Email, mail or fax it to us, and we'll handle all the details with your bank.

- New Authorization Change in Authorization Cancel Authorization

Note: All fields must be completed in order to process your autopay request. Any change in authorization will take approximately 30 days to make the appropriate change.

- Checking Account Savings Account

Bank Information Needed

Name of Financial Institution (Bank or Credit Union)

Account Number

Routing Number (This number should be obtained from your financial institution or can be found at the bottom left corner of your check – a 9-digit number.)

Member Information Needed

Member Name (Please Print)

Member ID Number

Address

City

State

ZIP Code

I give permission to AZ Blue to deduct money from my designated bank account using electronic funds transfers. This is to pay my monthly insurance premium. This authority is to remain in full force and in effect until AZ Blue has received notification from me of its termination in time to allow AZ Blue and my financial institution a reasonable opportunity to act on it.

*******Reminder: Prior to your first draft any outstanding billed amount will be deducted*******

I have read and agree to abide by the Autopay conditions as outlined on this authorization form. I understand that premium amounts may increase annually effective April 1 of each year.

Authorized Signature on Account

Date

Complete and sign form and submit to us:

By Email: memberhelp@azblue.com By Fax: **602-864-3116**

By Mail: Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466

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ACKNOWLEDGEMENT AND ATTESTATION for Medicare Supplement Household Discount



An Independent Licensee of the Blue Cross Blue Shield Association

MEMBER 1	First Name	Last Name		Middle Initial
	Member ID Number <i>(leave blank if Member ID Number has not been issued)</i>			
	Physical Street Address	City	State	ZIP
MEMBER 2	First Name	Last Name		Middle Initial
	Member ID Number <i>(leave blank if Member ID Number has not been issued)</i>			
	<input type="checkbox"/> Check here if Member 2's physical street address is the same as Member 1 listed above			

Acknowledgement and Attestation:

Blue Cross® Blue Shield® of Arizona (AZ Blue) offers a household discount to effective AZ Blue Medicare Supplement policy holders residing at the same residential address. Only Medicare Supplement policies qualify. The percentage of the household discount will vary depending on when the policy was written. Grandfathered Medicare Supplement policies written prior to 2018 will receive a 5% household discount and Non-Grandfathered polices written 2018 and after will receive a 7% household discount. Commercial, Individual, Group and Medicare Advantage policies do not qualify for the household discount. Assisted living facilities, group homes, and other non-residential settings do not qualify for the discount. AZ Blue may request additional documentation from any person applying for or receiving the discount.

I attest to the best of my knowledge that the individuals listed above are each enrolled in a Medicare Supplement policy issued by AZ Blue and meet all other eligibility requirements for the AZ Blue Medicare Supplement household discount. I understand and acknowledge that AZ Blue may periodically audit for continued discount eligibility, and I agree to provide any additional documentation requested by AZ Blue within the requested timeframe to verify eligibility.

AZ Blue reserves the right, upon thirty (30) days' notice to the members listed above, to terminate the household discount for any of the following reasons: (1) the household discount program has been discontinued; (2) the members, for any reason, voluntarily or involuntarily, no longer live at the same address; (3) the members, for any reason, voluntarily or involuntarily, are no longer current members of an AZ Blue Medicare Supplement plan.

If an active Medicare Supplement policy holder becomes deceased while enrolled in the household discount program, the household discount will continue to be applied to the surviving policy holder's premium through the policy end date, in accordance with payment terms and policy eligibility.

Termination of the household discount program does not terminate a member's individual policy with AZ Blue.

Applicant/Member 1 Signature

_____/_____/_____
Date

Applicant/Member 2 Signature

_____/_____/_____
Date

Mail this form to:

Blue Cross Blue Shield of Arizona **Attn:** Enrollment

P.O. Box 13466
Phoenix, AZ 85002-3466

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INSTRUCTIONS FOR COMPLETING THE CONFIDENTIAL INFORMATION RELEASE FORM



Please fill out this form if you would like Blue Cross® Blue Shield® of Arizona (AZ Blue) to share your information with the person or entity you mention on the form. Each member who is 18 or older has to fill out and sign a separate form for each person/entity.

Why might you want AZ Blue to share your information?

AZ Blue has to keep your information private. You can choose not to fill out the form, and we'll still sign you up for a plan, provide benefits, and pay your claims. AZ Blue needs this form if you want us to share your records with:

- Your spouse, parent, or child, so they can discuss claims questions with AZ Blue
- Your producer, after you sign up for a health plan, so he/she can help with claims
- Your lawyer, for an injury case

How to Fill Out This Form

Tell us whose records we can share. Write the name of the AZ Blue member this form is being completed for. Please include the group (if applicable) and member ID number.

Tell us who can get the records. This might be the name of a person, or it could be the name of a business, like a medical group, if you don't want us to send the records to a specific person.

Tell us which records we can share. Please check any applicable boxes in this section.

Tell us the purpose of sharing your records. Check at least one box.

Tell us when to stop sharing your information. You must check at least one box. If you check the box by "The date marked here," please write the date when we should stop sharing your information with this person or business. Check "No expiration" if you want the person or business to have access indefinitely. No matter which box you check, if you change your mind, you can also ask us to stop sharing your information at any time by writing to us.

Signature. If you are the member, print and sign your name and date the form.

Representative's Name/Signature. If you are signing the form because you are acting for the member, fill in your name, and sign and date the form. Include copies of any legal paper(s) that apply.

Questions? For questions about this form please call the number on the back of your ID card.

Please mail the completed form to:

AZ Blue

ATTN: Enrollment

P.O. Box 13466, Phoenix, AZ 85002-3466

OR Fax: 602-864-3116

OR Email: PrivacyOffice@azblue.com

CONFIDENTIAL INFORMATION RELEASE FORM



An Independent Licensee of the Blue Cross Blue Shield Association

Use this form to let a person or entity get your information. This form is voluntary. You can choose not to fill out this form, and we'll still sign you up for a plan, provide benefits, and pay your claims.

Person Whose Information We Are Sharing:

Name:	
Date of Birth: / /	Phone Number:
Member ID:	Group Number:

Person/Entity Receiving Your Information:

Name/Entity:	
Address:	
City, State, ZIP:	
Email Address:	Phone Number:
Allow this individual to change: <input type="checkbox"/> Address <input type="checkbox"/> Bank Information	

Records We Can Share*:

<input type="checkbox"/> Precertification Information	<input type="checkbox"/> Billing/Payment Information	<input type="checkbox"/> Application, Enrollment, Eligibility
<input type="checkbox"/> Medical or Dental Records, Procedure & Diagnosis Codes	<input type="checkbox"/> Account Information	<input type="checkbox"/> Claim/Explanation of Benefits
<small>*Some of these records may have details about contagious diseases, alcohol and drug abuse treatment, and genetic testing.</small>		

Purpose:

<input type="checkbox"/> To help with claims or payments	<input type="checkbox"/> To assist with care coordination	<input type="checkbox"/> At my request	<input type="checkbox"/> To appeal
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Tell Us When to Stop Sharing Your Information:

<input type="checkbox"/> The date marked here: / /	<input type="checkbox"/> No expiration
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Note: You may tell us to stop sharing your records at any time. If you want us to stop sharing, write to us at: AZ Blue Privacy Office, Mail Stop C300, P.O. Box 13466, Phoenix, AZ 85002-3466
If you tell us to stop sharing, it will not change what AZ Blue shared before you told us to stop.

Member Signature:	Date: / /
Representative's Name:	Relationship to AZ Blue Member:
Representative's Signature:	Date: / /

Note: If you are asking us to share records for someone other than yourself, attach a copy of any legal paper(s) that apply.

If you tell us to share your records with someone, the person who gets your records may not keep them private. Your records won't be protected anymore under federal privacy laws.

Please mail the completed form to:

AZ Blue
Attn: Enrollment
P.O. Box 13466, Phoenix, AZ 85002-3466
OR Fax: **602-864-3116**
OR Email: **PrivacyOffice@azblue.com**

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE COVERAGE

Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing Medicare supplement contract or Medicare Advantage insurance and replace it with a contract to be issued by AZ Blue. Your new contract to be issued by AZ Blue will provide thirty (30) days within which you may decide without cost whether you desire to keep the contract. You should review this new coverage carefully. Compare it with all accident and sickness coverage you have now. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this contract.

Statement to Applicant by Issuer, Agent, Producer, or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement contract will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement contract is being purchased for the following reason (check one):

- Additional benefits No change in benefits, but lower premiums Fewer benefits and lower premiums
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Explain reasons for disenrollment. _____
- Other (Please specify) _____

If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application which requests that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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 until you have received your new contract and are sure you want to keep it.

(Signature of Agent, Producer, or Other Representative)

Applicant's Signature _____	Date _____/_____/_____ (M M / D D / Y Y Y Y)
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Blue Cross Blue Shield of Arizona – P.O. Box 13466 – Phoenix, AZ 85002-3466

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- Disenrollment from a Medicare Advantage plan. Explain reasons for disenrollment. _____

- Other (Please specify) _____

If you still wish to terminate your present policy or contract and replace it with new coverage, be certain to truthfully and completely answer any and all questions on the application concerning your medical and health history. Failure to include all material medical information on an application which requests that information may provide a basis for the plan to deny any future claims and to refund your prepaid or periodic payment as though your contract 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 until you have received your new contract and are sure you want to keep it.

(Signature of Agent, Producer, or Other Representative)

Applicant's Signature _____	Date _____ / _____ / _____ (M M / D D / Y Y Y Y)
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