Washington State Health Care Authority
Medicare Supplement Enrollment Form

PREMERA BLUE CROSS

SECTION 1 – APPLICANT INFORMATION

APPLICANT		SPOUSE/QUALIFIED DOMESTIC PARTNER (QDP)	
Social Security Number (must include) ☐☐☐-☐☐-☐☐☐☐		Social Security Number (must include if applying) ☐☐☐-☐☐-☐☐☐☐	
Last Name First Name Initial		Last Name First Name Initial	
Date of Birth (month/day/year) / /	☐ Male ☐ Female	Date of Birth (month/day/year) / /	☐ Male ☐ Female
Home Address (cannot be a P.O. box)		City State ZIP	
Billing Address (if different from above; not applicable to PEBB/K-12 retirees)		City State ZIP	
Mailing Address (if different from above addresses)		City State ZIP	
Phone Number ( )		Medicare Supplement Plan Desired ☐ Plan E ☐ Plan J	

The Health Care Authority sets the effective date for PEBB/K-12 retirees. For all other applicants, coverage starts on the first of the month after the application postmark date, if all information is completed and accurate, and you meet the eligibility requirements in Section 2 below. To request a later effective date (no more than 90 days from postmark date), state residents should write that date here: ______/01/_______.
If you are replacing a Medicare Advantage plan, you must request to delay the effective date until after the date your Medicare Advantage coverage ends. If you need help with this, please contact us at 1-800-817-3049.

SECTION 2 – ELIGIBILITY

Public Employees Benefit Board (PEBB) and K-12 Retirees

To be eligible, you must be either an eligible PEBB or K-12 retiree or the eligible spouse or qualified domestic partner (QDP) of such a retiree. (See page 2 for more information about QDPs.) You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the time limits below. Please check the time limit that applies to you. Your spouse or QDP may enroll with you even if one of the events below does not apply to your spouse or QDP.

Check one; fill in the blank if needed.

☐ In the 30-day period before you become eligible for Part A and B of Medicare
☐ Within 60 days of retirement. Retirement date: ___________________________
☐ Within six months of initial enrollment in Medicare Part B
☐ Within six months after attaining age 65
☐ During an open enrollment period, if any, established by HCA for PEBB and K-12 retirees, only if you are transferring from another health plan with no lapse in coverage. Note: Existing PEBB and K-12 subscribers may change their coverage by applying for another program offered by the HCA only at the HCA's next open enrollment period for PEBB and K-12 retirees.

All Other Applicants
To be eligible, you must be a current Washington State resident. You must also be covered by Part A (Hospital Insurance) and Part B (Medical Insurance) of Medicare. You must enroll within one of the enrollment time limits below. Please check the time limit that applies to you. Your spouse or qualified domestic partner (QDP) may enroll with you even if one of the events below does not apply to your spouse or QDP. (See below for more information about QDPs.)

If you are under 65, and your enrollment in Parts A and B of Medicare was more than six months from the date of this application, please provide a copy of your Award Notice from Social Security.

Check one; fill in the blank if needed.
- ☐ Within 60 days of establishing Washington State residency. Resident date:____________________
- ☐ In the 30-day period before you become eligible for Part A and B of Medicare
- ☐ Within 60 days of retirement. Retirement date:____________________
- ☐ Within six months of initial enrollment in Medicare Part B
- ☐ Within six months after attaining age 65
- ☐ During an open enrollment period, if any, established by HCA for persons who are not PEBB or K-12 retirees, only if you are transferring from another health plan with no lapse in coverage.

Qualified Domestic Partner (QDP)
Your domestic partner may qualify for coverage if he or she meets the criteria on the Declaration Form (available to PEBB and K-12 retirees from the Health Care Authority) or if he or she is your same-sex domestic partner and meets the domestic partnership criteria under the Washington Secretary of State's Office (see www.secstate.wa.gov or call 360-725-0377).

Additional Application Periods for All Eligible Applicants
1. You can also apply for the HCA Plan E or J if one of the two conditions below is true.
   a. You left the HCA Plan E or J to try a Medicare Advantage program (including Medicare HMO or PPO programs), PACE program, or Medicare Cost, Risk, or SELECT program for the first time. You may apply if you tried one program, more than one program of the same type, or more than one type of program. However, all four statements must be true:
      - You were covered under each program you tried for less than 12 months.
      - Each program (other than the most recent) was terminated voluntarily.
      - You switched programs within 63 days of the date the prior program terminated, with no other coverage in between.
      - The effective date of the last program you tried was less than 24 months after the effective date of the first program you tried.

   b. If you are applying for the HCA Plan E and J offered only to people who have Medicare by reason of age, you can also apply if, at age 65 and first becoming eligible for Medicare Part A, you enrolled in one or more PACE programs or Medicare Advantage programs (including Medicare HMO or PPO programs). All four statements in part "a." above must also be true.
2. You can also apply for the HCA Plan E coverage if one of the conditions below is true.
   a. You lose retiree group coverage.
   b. Your Medicare supplement coverage ended because the carrier became bankrupt or insolvent.
   c. You were covered under a Medicare SELECT, Advantage, Risk or Cost program, or a PACE program, and your coverage ended or will end for one of the following reasons:
      - The program was withdrawn in your area.
      - You moved away from the program's service area.
      - The carrier or agent materially misrepresented the program or materially breached its terms.

You must give us proof that you had and lost the coverage as described above. If you qualify for coverage under 1. or 2. above, you must apply no earlier than 60 days before your prior coverage is to end and no later than 63 days after that coverage ended. **Note: If you qualify under 1. above, you may apply only for the HCA Medicare supplement plan you had originally. Please complete the questions in Section 3.**

SECTION 3 – PRIOR COVERAGE

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 a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. (See "Additional Application Periods for All Eligible Applicants" for details.)
Please answer all questions.

To the best of your knowledge,	You	Spouse/QDP (if applying)
1. a. Did you turn 65 in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No
b. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes ☐ No	☐ Yes ☐ No

c. If yes, what is the effective date? (Please fill in on the card below.)

All applicants and their spouses/QDPs, if applying, **must** fill in the boxes on the cards below with the information printed on their Medicare cards or include photocopy.
We cannot process your application without this information.

You

HEALTH INSURANCE

NAME OF BENEFICIARY
MEDICARE CLAIM NUMBER

IS ENTITLED TO	EFFECTIVE DATE
Part A Hospital Insurance	/ /
Part B Medical Insurance	/ /

Spouse or QDP (if applying)

HEALTH INSURANCE

NAME OF BENEFICIARY
MEDICARE CLAIM NUMBER

IS ENTITLED TO	EFFECTIVE DATE
Part A Hospital Insurance	/ /
Part B Medical Insurance	/ /

	You	Spouse/QDP (if applying)
2. Medicaid is a public aid program for people with low income. It is not the same as Medicare. 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.	☐ Yes ☐ No	☐ Yes ☐ No
a. Will Medicaid pay your premiums for this Medicare supplement coverage?	☐ Yes ☐ No	☐ Yes ☐ No
b. Do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? (**Important Note:** If you are receiving any kind of Medicaid assistance, you are not eligible to apply for this program.)	☐ Yes ☐ No	☐ Yes ☐ No
3. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, a PACE plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.	Start: / / End: / /	Start: / / End: / /

	You	Spouse/QDP (if applying)
b. If you are still covered under the Medicare plan in 3.a., do you intend to replace your current coverage with this new Medicare supplement plan? (**Important Note:** If you do not intend to replace your other Medicare plan, you are not eligible to apply for this program. Your new Medicare supplement plan cannot take effect while a Medicare Advantage plan is still in force.)	☐ Yes ☐ No	☐ Yes ☐ No
c. Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
d. Did you drop a Medicare supplement policy to enroll in the Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
4. a. Do you have another Medicare supplement policy or certificate in force?	☐ Yes ☐ No	☐ Yes ☐ No
b. If so, with which company and what plan do you have?		
Company ▶	____________	____________
Plan (A, B, C etc.) ▶	____________	____________
c. If so, do you intend to replace your current Medicare supplement policy with this coverage? (**Important Note:** If you do not intend to replace all other Medicare supplement coverage, you are not eligible to apply for this program.)	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?	☐ Yes ☐ No	☐ Yes ☐ No
a. If so, with which company and what kind of policy?		
Company ▶	____________	____________
Type of Policy ▶	____________	____________
b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End" blank.)	Start: ___/___/___ End: ___/___/___	Start: ___/___/___ End: ___/___/___

SECTION 4 – INFORMATION YOU NEED TO KNOW

A. Did you receive a copy of the Outline of Coverage? ☐ Yes ☐ No

B. Did you receive a copy of Medicare's "Choosing a Medigap Policy" guide? ☐ Yes ☐ No

C. You do not need more than one Medicare supplement contract.

D. If you purchase this coverage, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

E. If you are 65 or older, you may be eligible for benefits under Medic<u>aid</u> and may not need a Medicare supplement contract.

F. If, after purchasing this plan, you become entitled to Medicaid, the benefits and premiums under your Medicare supplement contract 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 plan (or, if that is no longer available, a substantially equivalent plan) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement plan provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your plan was suspended, the reinstituted plan will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

G. If you are eligible for and have enrolled in a Medicare supplement plan 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 plan can be suspended, if requested, while you are covered under the employer or union-based group health benefit plan. If you suspend your Medicare supplement plan under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement plan (or, if that is no longer available, a substantially equivalent plan) 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.

H. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement coverage 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).

SECTION 5 – BILLING

(STATE RESIDENTS ONLY -- DOES NOT APPLY TO PEBB OR K-12 RETIREES)

Please indicate your desired payment option (please do not send a payment at this time):

☐ Monthly Billing
☐ Monthly Automatic Funds Transfer (AFT)

If you select the AFT payment option you must sign and date the enclosed Automatic Funds Transfer Authorization form, and include a deposit slip or voided check from the account you will be using for payment.

SECTION 6 – SIGNATURE

I hereby apply for the Premera Blue Cross Group Medicare Supplement Plan, and agree to the terms of the contract offered. I understand that I must meet the applicable eligibility requirements and apply within the time limits that are shown on this form. ☐ **Yes** ☐ **No**. I understand that Premera Blue Cross may collect, use and disclose personal information about me as required or permitted by law to perform routine business functions, such as determining my eligibility for enrollment and benefits, paying claims and fulfilling other obligations stated in its contract with the Health Care Authority. If Premera Blue Cross discloses my personal information for any other reason, Premera Blue Cross will first remove any data that can be used to easily identify me or will get my signed authorization. I represent that the foregoing statements and answers are complete and true. I understand that all rights to payment of medical claims by Premera Blue Cross are void if any statement made by me herein is found to be false or incomplete. I understand that it is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

X ______________________________ X ______________________________

Applicant Signature Date Spouse/QDP Signature Date

CHECK LIST

To help us process your application faster, please take a moment to make sure that you have completed the following steps before you send your application.

1. You must be enrolled (or have proof of enrollment) in both Medicare Part A (Hospital Insurance) and Part B (Medical Insurance).
2. Fill in the sample Medicare card with the information on your own Medicare card or provide a copy of your Medicare card. We cannot process your application without your Medicare information.
3. You must answer all enrollment questions to the best of your knowledge.
4. Sign the application.
5. Include a copy of the certificate of coverage from prior insurer if needed to confirm prior coverage. If you are under 65, please include a copy of your Award Notice if needed (see Section 2).
6. To enroll your QDP, please return a completed Declaration Form, or a copy of your Certificate of State Registered Domestic Partnership or Registration Card with this application.

If you have any questions, please contact us at 1-800-817-3049 or TDD for the Deaf or Hard of Hearing at 1-800-842-5357.