

PART II. HEALTH/MEDICAL QUESTIONS (continued)

Height: _____ Ft. _____ In. Weight _____ Lbs.

1. In the last five years, have you had medical or surgical advice, treatment or consultation for any of the following conditions:
 - a. Yes No Heart attack, congestive heart failure, heart failure, enlarged heart or heart procedure or surgery (prior or not yet performed); aneurysm; peripheral vascular disease (poor circulation in your extremities); any stent placement; stroke or transient ischemic attack (TIA)?
 - b. Yes No Emphysema, chronic obstructive pulmonary disease (COPD), chronic bronchitis, tuberculosis or other chronic lung disorder (excluding mild or moderate asthma)?
 - c. Yes No Chronic kidney disease, kidney failure or kidney dialysis?
 - d. Yes No Crippling or disabling arthritis or bone disease, osteoporosis with fracture(s) or hip replacement?
 - e. Yes No Alzheimer's disease, dementia, organic brain disorder, any senility disorder, Parkinson's disease, Multiple Sclerosis, Amyotrophic Lateral Sclerosis (ALS) or Systemic Lupus?
 - f. Yes No Internal cancer, malignant melanoma, leukemia, Hodgkin's disease, lymphoma or bone marrow or organ transplant (except cornea)?
 - g. Yes No Diabetes in addition to any of the following: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure), **ever** had any amputation due to diabetes or **ever** required more than 50 units of insulin daily?
 - h. Yes No Alcohol or drug abuse or misuse, cirrhosis of the liver or other chronic liver disease?
 - i. Yes No Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV)?
 - j. Yes No Are you currently totally disabled, bedridden, hospitalized or confined to a nursing or other facility?
2. Yes No Do you need assistance, supervision or a wheelchair for any daily activities such as dressing, eating, bathing or walking?
3. In the last two years:
 - a. Yes No Have you had medical advice, treatment or consultation for any psychological, psychiatric, mental or nervous disorders?
 - b. Yes No Have you been advised or recommended to receive treatment for any condition that would require surgery, hospitalization or confinement to a facility?
 - c. Yes No Have you been advised by a physician to have medical tests, treatment or therapy that has not been performed?
 - d. Yes No Have you taken or been prescribed three or more prescription medications on a regular basis?

If you answer "Yes" to the above questions, please provide details below:

Question #	Date of Onset/Recovery	Condition/Daily Activity Limitations	Treatment/Medication/Type of Assistance Needed	Doctor Name/Phone #

4. Yes No Have you used tobacco in any form in the last two years?
5. Yes No Are you a diabetic controlled by diet or oral medications?
6. Yes No In the last 12 months, have you taken or been prescribed any prescription medications? If "Yes," please provide details for all medications below.

Medication	Date Started/Stopped	Dosage/Frequency	Reason for Taking Medication

Please list additional medications on a separate sheet of paper and submit the list with this application.

PART III. EXISTING COVERAGE INFORMATION (complete in full)

- 1. a. Do you have another Medicare Supplement insurance policy in force? Yes No
- b. Have you had coverage under other health insurance other than Medicare Advantage within the past 63 days? (For example, an employer, union or individual plan.) Yes No
- c. If so, with what company and what plan do you have?

Name of Company	Policy/Certificate Number	Plan/Kind of Policy	Issue Date

- d. If so, do you intend to replace your current policy with this policy? Yes No
- e. If "Yes," indicate termination date: _____
Mo. Day Yr.

YOU MUST NOTIFY YOUR EXISTING INSURANCE COMPANY OF YOUR TERMINATION DATE.

- 2. a. Have you had coverage from any Medicare plan other than the original Medicare within the past 63 days? (For example, a Medicare Advantage plan or a Medicare HMO or PPO.) Yes No
Fill in your start and end dates below. If you are still covered under this plan, leave "End" blank.
Start: _____ / _____ / _____ End: _____ / _____ / _____
- b. 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
- c. Reason for termination/disenrollment: _____
- d. Planned date of termination/disenrollment: _____ / _____ / _____
- e. Was this your first time in this type of Medicare plan? Yes No
- f. Did you drop a Medicare Supplement policy to enroll in this Medicare plan? Yes No

YOU MUST NOTIFY YOUR EXISTING INSURANCE COMPANY OF YOUR TERMINATION DATE.

- 3. Are you covered for medical assistance through the **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
- If "Yes,"
- a. Will Medicaid pay your premiums for this Medicare Supplement policy? Yes No
- b. Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? Yes No

IMPORTANT NOTE: If you are replacing a current Medicare Supplement plan, group coverage, Medicare HMO or PPO coverage or Medicare Advantage coverage with our Medicare Supplement plan, the pre-existing conditions exclusions will not apply to you.

Producer Use Only

- a. List policies sold which are still in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

- b. List policies sold in the past five years which are no longer in force.

Name of Company	Policy/Certificate Number	Description of Benefits	Effective Date of Coverage

PART IV. IMPORTANT STATEMENTS TO BE READ BY APPLICANT

Consumer Protection Information

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- 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).
- 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 policy (or, if that policy is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If your 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 suspension.

Please Read and Sign this Portion of the Enrollment Form

Read carefully before signing: To determine my insurability or for claims purposes, I authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, insurance company, institution or person that has any past and future medical records or knowledge of my health to give to Blue Cross and Blue Shield of South Carolina, or any of its reinsurers, any such information. I understand and agree that this authorization will remain valid: (a) for the purpose of collecting information to determine my insurability for 24 months from the date I sign this application and (b) for the purpose of collecting information in connection with a claim for benefits for the period of time I am covered under the policy. I understand that I or any person authorized to act on my behalf is entitled to receive a copy of this authorization. A photocopy of this authorization shall be as valid as the original.

I acknowledge receipt of: 1) an Outline of Coverage and the Medicare Supplement Buyer's Guide; 2) a listing of network hospitals participating in the Blue Select program; 3) a description of Blue Select plan benefits when services are provided in non-network hospitals; 4) a description of the grievance procedures; and 5) a description of the Quality Assurance program.

I understand Blue Select plan benefits will not be paid for the Part A Medicare deductible when hospitalized in a non-network hospital unless the hospitalization was for emergency treatment as defined by Medicare (Title XVIII of Social Security Act as amended) or when the services are not available at a network hospital.

I understand, at the time of my application for the Blue Select policy, I have the opportunity to purchase any Medicare supplement policy, without restricted network provisions, offered by Blue Cross and Blue Shield of South Carolina. After the Blue Select policy has been in force for at least six consecutive months, I may request the opportunity to purchase, without evidence of insurability, a Medicare supplement policy offered by Blue Cross and Blue Shield of South Carolina that has comparable or lesser benefits and that does not contain a restricted network provision.

I agree that the information given by me on this application is complete, true and correctly recorded and this application will become a part of my contract. My coverage will not become effective until Blue Cross and Blue Shield of South Carolina accepts this application and until the premium plus any policy fee is paid. Approval may be based on my insurability as stated in my application. Coverage will become effective on the 1st or the 15th of the month.

I understand that I must be a South Carolina resident, have both Medicare Parts A and B and be at least age 65.

I will have a six-month pre-existing limitation period from the effective date of the policy before I can receive benefits for any pre-existing conditions for which I have received medical advice or treatment during the six-month period immediately prior to my policy effective date.

Applicant's Signature: X _____ **Date:** _____

Agent's Signature: X _____ **Code:** _____ **Date:** _____

Authorization Agreement For Bank Draft/Credit Card Payments

If you choose Monthly Bank Draft or Credit Card, complete the authorization agreement below and attach a voided check, if applicable.

Bank Draft Bank Name: _____ Bank Routing Number: _____

City: _____ State: _____ ZIP: _____

My Account No.: _____ Name on Account: _____

Credit Card Visa Master Card Discover Expiration Date: _____

My Account No.: _____ Name on Account: _____

Corporation Name: Blue Cross and Blue Shield of South Carolina

I authorize Blue Cross and Blue Shield of South Carolina to initiate debit/charge entries to my checking account/credit card below and the Bank/Corporation named to debit/charge my account.

This authority is to remain in force until the Bank/Corporation has received written notification from me of its termination in such time and such manner as to afford the Bank/Corporation a reasonable opportunity to act on it. A customer has the right to stop payment of a debit entry by notifying the Bank/Corporation prior to charging the account. If Blue Cross and Blue Shield of South Carolina initiates an erroneous debit entry to a customer's account, the customer shall have the right to have the amount of the entry credited to his/her account by the Bank/Corporation. If, within 15 calendar days following the date on which the Bank/Corporation sent to the customer a statement of account or written notice pertaining to the entry or 46 days after posting, whichever occurs first, the customer shall have sent to the Bank/Corporation a written notice identifying the entry, stating that the entry was in error and requesting the Bank/Corporation to credit the amount to his/her account.

Your Name: _____ I.D.# _____

Signed: X _____ Date: _____

For Use of Blue Cross and Blue Shield of South Carolina

Effective Date	End Date	Cancel	Process	I.D. Code	Accept	Reject	Underwriting