



1 Cameron Hill Circle
Chattanooga, TN 37402
www.bcbst-medicare.com

- Confidential -
Use Black Ink Only



ID: _____
Group No: 123776
PHC

SECTION 1 – APPLICANT Personal Information -

Last Name	Jr., Sr., etc.	First Name	MI	Social Security Number

Sex: Male Female Date of Birth (mm/dd/yyyy)

Address (P.O. Box is NOT sufficient – Please provide place of residence)

City (Please do not abbreviate)	State	Zip Code	County of Residence
	T N		

Mailing Address If Different (P.O. Box IS sufficient)

City (Please do not abbreviate)	State	Zip Code	Daytime Phone

Email Address**

***In the event a policy is issued, by providing your email address you are agreeing to receive all communications (presently available or that become available during the term of your policy) related to this policy, the benefits contemplated under this policy, your relationship with BlueCross BlueShield of Tennessee, etc., in electronic form from BlueCross BlueShield of Tennessee.*

Fill in these boxes so they match your red, white, and blue Medicare card:

Medicare Claim Number:

Medicare Part A (Hospital) Effective Date (mm/dd/yyyy):

Medicare Part B (Medical) Effective Date (mm/dd/yyyy):

You must have Medicare Part A and Part B to join a BlueElite plan.

We cannot consider this application complete until you have given us this information.

SECTION 2 - Benefit Section - To receive benefits, you must be enrolled in Medicare Part A and Part B.

I am applying for the type of BlueElite coverage checked below (Check Only One Box):

Plan A Plan D Plan F

Desired Effective Date (mm/dd/yyyy):

I ask to:

Become a Subscriber

Change my BlueElite Plan

Applicant Last Name

Grid for Applicant Last Name

First Name

Grid for First Name

MI

Grid for MI

Social Security Number

Grid for Social Security Number

SECTION 3 – Health Questions - If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 3 and GO TO SECTION 4.

Height: Feet Inches

Weight: Pounds

Have you used tobacco in any form in the past 12 months? Yes No

For each question answered "YES," **circle** the applicable condition.

Yes No

- 1. Within the past **ten (10) years**, have you been treated for or diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?
- 2. Within the past **five (5) years**, have you had or been advised to have treatment, surgery or to take prescription medication for:
 - a. Cancer (excluding basal or squamous cell), Hodgkin’s disease, leukemia, or melanoma; even if the conditions are in remission?
 - b. Congestive heart failure, coronary artery disease, peripheral vascular disease, circulatory disorder (excluding high blood pressure), heart disease, enlarged heart, transient ischemic attack, stroke, heart or heart valve surgery, angioplasty, pacemaker, or stent placement?
 - c. Uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison’s disease, kidney failure, nephritis, renal insufficiency or kidney dialysis or gangrene?
 - d. Emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?
 - e. Paget’s disease, rheumatoid or disabling arthritis, lupus or other bone or connective tissue disorder?
 - f. Mental or nervous disorder requiring psychiatric treatment, organic brain disorder, Alzheimer’s disease, ALS (Lou Gehrig’s disease), muscular dystrophy, myasthenia gravis, Parkinson’s disease, multiple sclerosis, cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders or alcohol or drug abuse?
 - g. Are you permanently confined to a nursing facility, permanently bedridden or confined to a wheelchair?
 - h. Have you been admitted to a hospital three or more times in the last two years?

Applicant Last Name

Grid for Applicant Last Name

First Name

Grid for First Name

MI

Grid for MI

Social Security Number

Grid for Social Security Number

SECTION 4 – Current or Previous Health Insurance

To the best of your knowledge:

Yes No

- 1. Do you have another Medicare supplement policy or certificate in force (including health care service contracts, health maintenance organization contracts)?

(a) If so, with what company?

Text box for company name

Company Phone Number:

Grid for company phone number

- 2. Do you have or have you had any other health insurance policy within the last 63 days?

(a) If so, with what company?

Text box for company name

Company Phone Number:

Grid for company phone number

(b) What kind of policy (i.e., group, Medicare Advantage, etc.)?

Text box for policy type

(c) What is/was your policy number?

Text box for policy number

(d) Effective Date (mm/dd/yyyy):

Grid for effective date

Termination Date (mm/dd/yyyy):

Grid for termination date

Is this policy still in effect? Yes No

Termination Reason:

Text box for termination reason

- 3. If the answer to either of the above questions is "Yes," do you intend to replace these medical or health policies with the BlueElite plan you applied for? If "Yes," please attach a copy of the Replacement Notice included in your enrollment package.

- 4. Are you covered by or have you applied for TennCareSM (or Medicaid), the state/federal program for the categorically indigent?

(a) Have your TennCareSM benefits been discontinued in the last six (6) months? Yes No

If "Yes," what were the beginning and end dates of your TennCareSM policy?

Beginning Date (mm/dd/yyyy):

Grid for beginning date

End Date (mm/dd/yyyy):

Grid for end date

