Empire BlueCross BlueShield
An Anthem Company

Application for Medicare Supplement – New York

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116

Instructions

For assistance, call us at **1-888-849-2420**. To be considered for coverage, you must live in **New York**. Please answer all questions fully. Submit application within 90-days of signature date.

Important Statements

Please read the six statements below.

1. **You do not need more than one Medicare Supplement policy or certificate.**
2. If you purchase this policy (certificate), 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 (certificate).
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.
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 the 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).

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☐ New Enrollment
☐ Change to Existing Empire Medicare Supplement Plan

Section A: Applicant Information (Please print and use black ink only.)

Last Name	First Name	MI	Sex ☐ M ☐ F
Home Street Address (Physical Address, not a P.O. Box)			Apt #
City	County	State	Zip Code
Mailing Address (if different than above)	City	State	Zip Code
Billing Address (if different than above)	City	State	Zip Code
Date of Birth (MM/DD/YYYY) / /	Age	Home Phone Number ( )	

Language Preference (Optional): ☐ Decline
Written Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____
Spoken Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other _____

Please complete the information below using your Medicare card (include all letters and numbers).

Medicare Claim Number: _____

Hospital (Part A) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Medical (Part B) Effective Date: _____ (MM) / 01 (DD) / _____ (YYYY)

Section B: Plan Selection

I would like to apply for Medicare Supplement Plan (check only one box):

☐ Plan A ☐ Plan B ☐ Plan F ☐ Plan G ☐ Plan N

Policy Effective Date: _____ (MM) / _____ (DD) / _____ (YYYY)

Coverage is effective as of the 1st of the month following approval of your completed application. To ensure continuation of coverage, you can request an initial effective date other than the 1st of the month. The effective date must be within 90-days of application signature. After the initial effective date, your policy will move to a 1st of the month anniversary date.

Have you purchased a stand-alone Prescription Drug Plan (PDP)? ..... ☐ **Yes** ☐ **No**

a. If yes, with what company? _____ PDP Effective Date: ____ / ____ / _____

(continued)

Section C: How Do You Wish to Pay Your Premium? (SEND NO MONEY NOW!)

Automated Bank Draft*

- ☐ Monthly – save $2 per month
- ☐ Quarterly
- ☐ Annual – save $48 per year

Paper Bill (Send to **Billing Address** in Section A)

- ☐ Quarterly
- ☐ Annual – save $48 per year

* Please complete the **Premium Payment Form**. Drafts are made to your account on the 5th day of the month.

Section D: Other Coverage Information

RESPONSES TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR YOUR PROTECTION. To the best of your knowledge and belief, please answer all questions by marking "Yes" or "No" with an "X". If you recently lost, are losing or replacing other health insurance coverage and received a notice stating 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 with your Application.**

1. a. Did you turn age 65 in the last 6 months? ☐ **Yes** ☐ **No**

b. Did you enroll in Medicare Part B in the last 6 months? ☐ **Yes** ☐ **No**

If yes, what is the effective date? _____

2. Are you covered for medical assistance through the state Medicaid program? ☐ **Yes** ☐ **No**

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.

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** payments toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

3. a. If you had coverage from any Medicare Advantage plan other than Original Medicare within the past 63 days (for example, a Medicare HMO, PPO or PFFS), fill in your start and end dates below. If you are still covered under the Medicare Advantage plan, leave "END" blank. (If you know your upcoming coverage end date, then enter that date).

START _____ / _____ / _____ END _____ / _____ / _____

b. If you are still covered under the Medicare Advantage plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ☐ **Yes** ☐ **No**

c. Was this your first time in this type of Medicare Advantage plan? ☐ **Yes** ☐ **No**

d. Did you drop a Medicare Supplement policy to enroll in the Medicare Advantage plan? ☐ **Yes** ☐ **No**

4. a. Do you have another Medicare supplement or Medicare Select policy or certificate in force? ☐ **Yes** ☐ **No**

b. If so, with what company, and what plan do you have?

Company: _____ Plan: _____

If so, do you intend to replace your current Medicare Supplement or Medicare Select policy or certificate with this policy or certificate? ☐ **Yes** ☐ **No**

(continued)

Section D: Other Coverage Information *(continued)*

5. Have you had coverage under any other health insurance policy or certificate within the past 63 days? (for example, an employer, union or individual plan) ☐ **Yes** ☐ **No**

a. If yes, Company: _____ Policy Type: _____

b. If yes, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. If you know your coverage end date, then enter that date.)

START _____ / _____ / _____ END _____ / _____ / _____

Policy Number: _____ Customer Service Phone Number: _____

Section E: Authorizations and Agreements

I, the applicant or my authorized representative:

1. affirm all answers provided on this application are true, complete and correct **(including information relating to Medicare coverage) and that any false statement or misrepresentation on the Application may result in loss of coverage under the policy** and that it is my/our responsibility for accurately completing this Application;

2. understand if coverage is rescinded for fraud or intentionally misleading statements Empire BlueCross BlueShield will reimburse any premium paid less any claims paid and I/we will be responsible for claims paid exceeding any premium paid;

3. understand that I/we are responsible for notifying Empire BlueCross BlueShield in writing of any new/changes to information on this application before coverage becomes effective that makes my application incorrect or incomplete;

4. understand that there is a six-month benefit waiting period for any condition that I received medical treatment or advice in the six months prior to the effective date of this Medicare Supplement policy. Prior health insurance coverage will be counted toward this 6-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

5. understand the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy, premium or terms of any Company coverage and that he/she may be compensated based on my enrollment;

6. understand upon acceptance that my Application will become part of the agreement between the Company and myself;

7. authorize Empire BlueCross BlueShield to use and disclose my personal information when necessary for the operation of my health or other related activities and that Empire BlueCross BlueShield will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

8. understand that my payment by check (or resubmission due to insufficient funds) may be converted to an electronic Automated Clearinghouse (ACH) debit transaction, that my check will not be returned to me and that this process will not enroll me in any automatic debit process;

Section E: Authorizations and Agreements *(continued)*

9. acknowledge responsibility for any overdraft fees permitted by state law;

10. acknowledge receipt of:

- Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare,*
- the *Outline of Coverage,* and
- a copy of this Application.

Section F: Policy Issuance

IMPORTANT: This Application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in the Application.

Please do not cancel your present coverage, if any, until you receive documentation from Empire BlueCross BlueShield, such as an ID card or written notification, showing that your Application has been approved.

To ensure timely processing, verify the following:

1. Complete, sign and date all sections as indicated by signature boxes.
2. If you want the convenience of automatic bank draft for payment purposes, be sure to complete the **Premium Payment Form.**
3. If replacing a Medicare Supplement or Medicare Advantage policy, the **Replacement Notice** is signed and dated by both you and your insurance agent (if applicable) and returned with your Application.

Please mail the entire Application (including any additional forms) to the address below:

Empire BlueCross BlueShield
P.O. Box 659816
San Antonio, TX 78265-9116

OR, fax to: 1-844-236-7967

Signature of Applicant, or Authorized Representative (if applicable)* PLEASE MAKE A COPY FOR YOUR RECORDS. **X**	Date

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

*If signed by an Authorized Representative, a copy of the authority to represent applicant must be attached to Application (such as a Power of Attorney).

— SEND NO MONEY NOW —
PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.

Section G: Agent/Broker Information Only: If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

IMPORTANT: Before this form can be processed, the agent/broker's current health and life license must be on file. In addition, the agent/broker must be appointed with us.

Agent/Broker No.:

_____

Agency No.:

_____

(Any commission will be processed using these identification numbers.)

Agent/Broker's Printed Name:

_____

Phone No.: (_____) _____

Fax No.: (_____) _____

Street Address: _____

City: _____ State: _____ ZIP Code: _____

Email Address: _____

Attestation – Please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this Application by phone, e-mail or in person.

☐ I certify that the applicant has read, or I have read to the applicant, the completed Application. To the best of my knowledge, the information on this Application is complete and accurate. I explained to the applicant, in easy-to understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I certify that the applicant realizes that any false statement or misrepresentation in the Application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

List all health insurance policies sold to the applicant that are still in force:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

List all health insurance policies sold to the applicant in the past five (5) years that are no longer in force:

Company Name	Policy/ Certificate Number	Type of Coverage	Policy Effective Date	Policy Term Date (if applicable)

(continued)

Section G: Agent/Broker Information Only: *(continued)* If Application is being made through an agent/broker, he or she must complete the following, and the Notice of Replacement included with the Application, if appropriate. *(Attach additional sheets if necessary.)*

I have read and understand the Application. I certify that the applicant has both Medicare Parts A and B, I have given the applicant the *Guide to Health Insurance for People with Medicare*, the *Outline of Coverage* for the policy applied for and a copy of this application. I have requested and received documentation that indicates that the policy applied for will not duplicate any health insurance coverage. I have verified the information in the Replacement Notice section. I have reviewed the current health insurance coverage of the applicant and find that additional coverage of the type and amount applied for is appropriate for the applicant's needs.

Agent/Broker's Signature: X _____ **Date of Signature:** _____

Notice to Applicant Regarding Replacement of
Accident and Health Insurance, HMO Coverage or Employer-provided Health Benefit Arrangement

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116

Save This Notice! It May Be Important to You in the Future.

According to information you have furnished, you intend to terminate your existing existing accident and health insurance, health maintenance organization coverage or employer-provided health benefit coverage and replace it with a policy to be issued by Empire HealthChoice Assurance, Inc. Your new policy will provide thirty (30) days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all health coverage you now have and evaluate the need for existing coverage that may duplicate this policy (certificate). Terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

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

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction (does) (does not) duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) checked below:

- ☐ 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 Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy (certificate). This could result in denial or delay of a claim for benefits under the new policy (certificate), whereas a similar claim might have been payable under your present coverage. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)
2. State regulation provides that in applying a preexisting condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)
3. If you still wish to terminate your present policy or certificate and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

X _____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales

Notice to Applicant Regarding Replacement of
Accident and Health Insurance, HMO Coverage or Employer-provided Health Benefit Arrangement

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P.O. Box 659816 • San Antonio, TX 78265-9116

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- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  _____

- ☐ Other. (please specify) _____

1. Health conditions which you may presently have may be considered preexisting conditions and may not be immediately or fully covered under the new policy (certificate). This could result in denial or delay of a claim for benefits under the new policy (certificate), whereas a similar claim might have been payable under your present coverage. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)
2. State regulation provides that in applying a preexisting condition limitation, a Medicare supplement issuer must credit the time the applicant was previously covered under creditable coverage (including Medicare supplement insurance, Medicare select coverage and Medicare Advantage plans) if the previous creditable coverage was continuous to a date not more than 63 days prior to the enrollment date of the new policy or certificate. (This paragraph may be deleted if the replacement does not involve application of a new preexisting condition limitation.)
3. If you still wish to terminate your present policy or certificate and replace it with new coverage, review the application carefully before you sign it to be certain that all information has been properly recorded.

X _____
(Signature of Agent, Broker or Other Representative)*
Typed Name and Address of Issuer, Agent or Broker

X _____ _____
(Applicant's Signature) (Date)

*Signature not required for direct response sales

Empire HealthChoice Assurance, Inc.
P.O. Box 659816
San Antonio, TX 78265-9116
Fax: 1-844-236-7967

Empire BlueCross BlueShield
An Anthem Company

Medicare Supplement - Premium Payment Form

With Automatic Bank Draft, Empire BlueCross BlueShield
will automatically draft your premium directly from your checking account.

Simplify your life! It saves you valuable time and money.

Pay annually and save $48 or sign up for monthly Automatic Bank Draft and save $2 per month. ... It is easy to sign up!

(Available on policies with an effective date on or after June 1, 2010.)

Full Name (please print):		**Phone**	
Home Street Address (Physical Address, not a P.O. Box)			**Apt. #**
City	**County**	**State**	**ZIP Code**
Mailing Address (if different than above)	**City**	**State**	**ZIP Code**
Billing Address (if different than above)	**City**	**State**	**ZIP Code**

☐ EXISTING MEMBER (Changing Payment Option to Automatic Bank Draft)

Empire BlueCross BlueShield Identification Number (as shown on ID card): _____

(Allow 6-8 weeks to process your authorization. Continue to pay as billed until receiving a confirmation letter that we have set up Automatic Bank Draft for your premiums.) For existing members, return this form to: Empire HealthChoice Assurance, Inc. P.O. Box 659816, San Antonio, TX 78265-9116

☐ NEW APPLICANT (Initial Submission of a Medicare Supplement Application)

I understand that the premium for the coverage I have selected is $_____.*

** If your application is accepted and the amount you indicated is less or more than the actual premium amount, the difference will be reflected as a debit or credit on the first bill you receive. If the amount received is not within our payment guideline threshold, we will notify you.* ***To ensure proper payment setup, this form MUST be returned with your Application.***

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your Premium Billing Preference selection does not guarantee your Premium for any specific time period. The policy renewal date is defined as generally January 1, subject to state approval. Please refer to your *Outline of Coverage* for additional information regarding changes in Premiums.

BANK INFORMATION (For Existing Member)

Deduct Premium: ☐ Monthly* ☐ Quarterly ☐ Annually*
(* Applicable discounts for monthly or annual Automatic Bank Draft are not guaranteed and are subject to change.)

Deduct Monthly Premium From: ☐ Checking Account **Start Date:** _____/____/_____

Is this a business account: ☐ Yes ☐ No

Account Holder Name(s):

Name of Financial Institution:

Bank Routing/Transit Number (9 digits)	Bank Account Number
_ _ _ _ _ _ _ _ _	_____

I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium, and the designated financial institution named above to debit the same account.

I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Empire BlueCross BlueShield when set up, I authorize my bank to draft both the past due premium along with current premium to ensure my coverage stays in effect. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception:** In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Empire BlueCross BlueShield and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction and that I will not receive a bill.

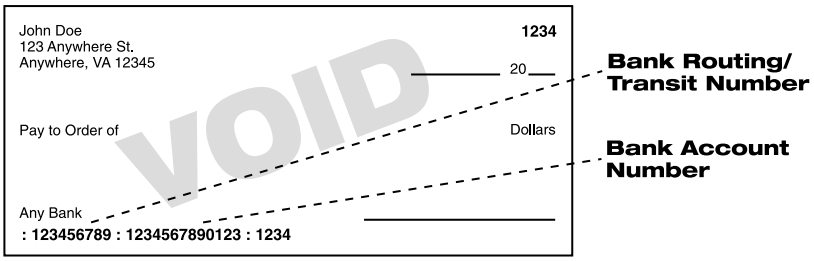
Empire will accept premium payments made on behalf of an applicant or member from **ONLY** the following:

- Family member related by blood, marriage or adoption;
- Legal Guardian and/or Conservator;
- Powers of Attorney; or
- a Trustee acting on behalf of the member that is a Beneficiary of the Trust.

Return this authorization as indicated above. **No service fees apply when paying by Automatic Bank Draft.**

Account Holder's Signature (as it appears on your bank account)	**Date**

Refer to the image below to identify where to locate the Routing Number and Bank Account Number. Do not include the check number as part of the Routing or Account Number



Services provided by Empire HealthChoice Assurance, Inc., licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Empire BlueCross BlueShield

An Anthem Company

AUTHORIZATION FOR THIRD PARTY DESIGNATION TO RECEIVE NONPAYMENT OF PREMIUM NOTICES

Under New York law, you may choose someone (called a third party designee) to get notices if we do not receive your Medicare Supplement insurance premium. In the event your premium is not received by its due date, a THIRD PARTY BILLING STATEMENT will be sent to this designated person. If your coverage is terminated for non-payment, we will also send a THIRD PARTY TERMINATION letter to this designee. This is optional and can be done at the time of Application or at a later date. Both you and the person you choose must sign this form.

Please note that for designation purposes, Empire will accept premium payments made on behalf of an applicant or member from **ONLY** the following:

- Family member related by blood, marriage or adoption;
- Legal Guardian and/or Conservator;
- Powers of Attorney; or
- a Trustee acting on behalf of the member that is a Beneficiary of the Trust.

THIRD PARTY DESIGNEE INFORMATION:

Last Name | **First Name** | **Middle Initial**

Mailing Address | **Apartment Number**

City | **State** | **Zip Code**

Telephone Number

I understand that, as third party designee, I must notify both the member and Empire HealthChoice Assurance, Inc. in writing if I decide to terminate the Designation and affirm that I meet the above guidelines as to whom may serve as a Designated Third Party.

Designated Third Party Signature | Date

(Continued on back)

Applicant, Member Information:

Member Name: _____

Empire Medicare Supplement Member Identification Number: _____ (required)

Date of Birth:_____

I authorize Empire HealthChoice Assurance, Inc. to send, to the Third Party Designee, a THIRD PARTY BILLING STATEMENT and a THIRD PARTY TERMINATION letter for the member named above.

This Authorization is valid for the duration of my coverage with Empire unless a different expiration date is indicated here: _____ (specify month, day, year).

I understand that this Designation does not include the ability to make decisions concerning my health care. I also understand that I may revoke this designation at any time, except to the extent that action has been taken in reliance upon it, by submitting a request in writing to Empire. I understand that the person/entity I have named to receive information may not be subject to privacy laws. They may be able to release the information and privacy laws may no longer protect the information.

I do hereby affirm that I am the member or the person with the legal authority (appropriate legal documentation must be provided) to act on behalf of the applicant, member and affirm my Designated Third Party meets the above guidelines as to whom may serve as a designee.

_____ _____

Applicant, Member/Legally Authorized Person Signature Date

_____

Authority of person signing form (e.g., Power of Attorney)

Mail to:

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P.O. Box 659816
San Antonio, TX 78265-9116