Plan 65® Health Insurance Application

Please be sure to complete **ALL** information below to avoid delays in processing and refer to page 3 of the Plan 65 Sales Brochure for eligibility information. Please type or print clearly using blue or black ink.

Section 1 Applicant Information

Last name		Suffix	First name		M.I.
Home address (street/apartment number)			City/town	State	ZIP code
Mailing address (if different)(street/apartment number, city/town, state, ZIP code)					
Date of birth (mm/dd/yyyy)	Gender ☐ M ☐ F	Social Security number (xxx-xx-xxxx)		Current BCBSRI ID (if applicable)	
Home phone number			Cell phone number		
What is your primary language spoken?					
What is the name of your prior health insurance carrier? ____________ ____________	What was the date of coverage termination? (mm/dd/yyyy) ____________ Please attach a copy of certificate of creditable coverage showing coverage end date. Application will not be processed until received.				

Please provide your Original Medicare beneficiary information, Medicare claim number, and effective dates below.

Medicare Claim Number

Medicare Hospital Insurance (Part A)
Effective Date: Month/Day/Year

Medicare Medical Insurance (Part B)
Effective Date: Month/Day/Year

Health Insurance and Social Security Act

Name of beneficiary:

Medicare claim number:

__ __ __ - __ __ - __ __ __ __ __

Effective dates:

Part A (hospital) ____ / ____ / ____

Part B (medical) ____ / ____ / ____

Section 2 Health Plan Options

Requested effective date (mm/yyyy): ____ / ________

Billing frequency and type (choose one):

☐ Monthly by mail ☐ Quarterly by mail

☐ Monthly electronic funds transfer (EFT) (deducted from your bank account)
If you are interested in the EFT payment option, please contact us at (401) 459-5000 or 1-800-639-2227 (outside Rhode Island).

Medical coverage applied for:

☐ Plan 65A ☐ Plan 65C ☐ Plan 65 Select C

continued ➤

Section 3 Eligibility

You do not need more than one Medicare Supplement policy.

If you purchase the policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

The benefits and subscriber fees 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, please notify us to have your Medicare supplement policy reinstituted. You must notify us within 90 days of losing Medicaid eligibility.

Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and Specified Low-income Medicare Beneficiary (SLMB).

To the best of your knowledge:

☐ Yes ☐ No Do you have another Medicare supplement insurance policy or certificate in force?
If so, with which insurer? ____________________

☐ Yes ☐ No If so, do you intend to replace your current Medicare supplement policy with this policy?

☐ Yes ☐ No Do you have any other health insurance coverage that provides benefits similar to this Medicare supplement policy?____________________
If so, with which insurer? ____________________
What kind of policy? ____________________

☐ Yes ☐ No Do you have a Medicare Advantage policy?
If so, with which insurer? ____________________

☐ Yes ☐ No Are you covered by medical assistance through the state Medicaid program?
☐ Yes ☐ No As a Specified Low-income Medicare Beneficiary (SLMB)?
☐ Yes ☐ No As a Qualified Medicare Beneficiary (QMB)?
☐ Yes ☐ No For other Medicaid medical benefits?

☐ Yes ☐ No Are you transferring from an out-of-state Medicare supplement plan?
If yes, please include the name and state of the Medicare supplement plan:
____
Plan type: ____________________

☐ Yes ☐ No I have received the **Notice of Replacement Coverage.**
☐ Yes ☐ No Are you eligible for group healthcare through an insurer?
If yes, please provide the name of the company or group: ____________________

Section 4 Plan 65 Select C Disclosure Statement

I have received the following information and understand the restrictions of the Plan 65 Select C benefit plan I have chosen.

- An outline of coverage comparing the Plan 65 Select C benefit plan I have chosen with all Plan 65 Select C benefit plans offered by Blue Cross & Blue Shield of Rhode Island (BCBSRI)
- A listing of the Plan 65 Select C hospital network
- A description of benefits, coinsurance, and deductibles applicable when Plan 65 Select C participating hospitals are used
- A description of coverage for emergency and urgently needed care and other out-of-service area coverage
- A description of limitations on referrals to Plan 65 Select C non-participating hospitals
- A description of my right to purchase any other Medicare supplement contract offered by BCBSRI

Section 5 Signature

By signing this application, I certify and agree that:

1. I have read the above statements, or that they have been read to me; and all responses on this application are the truth, as best I know. If anyone knowingly lied or hid the truth, BCBSRI will have the right to:
   - Reduce or deny a claim; and
   - Cancel the plan, back to the effective date; and
   - Recoup any monies paid, back to the effective date.
2. The applicant is the responsible person for the payment of premiums.
3. No covered benefits will apply until the plan is made effective by BCBSRI.

____
Signature of Applicant Date

Section 6 Contact Information

Please mail this form to: Blue Cross & Blue Shield of Rhode Island
Individual Sales Department
500 Exchange Street, Providence, Rhode Island 02903-2699

For questions, call: Individual Sales Department (401) 351-BLUE (2583) or
1-800-505-BLUE (2583) (outside of Rhode Island)

INTERNAL USE ONLY

Sales rec'd __________ Sales eff. date __________ ID# __________ Eligibility A T Q N O Other __________

Complete date __________ Initial _____

www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

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