Plan 65® Health Insurance and Dental Insurance Application

Blue Cross Blue Shield of Rhode Island

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?	Email address

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 your certificate of creditable coverage showing the coverage end date, unless you are enrolled with BCBSRI or are new to Medicare Part B. 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 and Dental Plan Options (You may select Plan 65 coverage, Dental coverage, or both.)

Plan 65 coverage applied for:
☐ Plan 65 A ☐ Plan 65 F ☐ Plan 65 Select F

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

If you are applying for Blue Cross Dental coverage, please check box. ☐

Dental coverage applied for: ☐ Dental Direct Basic ☐ Dental Direct Essential ☐ Dental Direct Plus

Requested dental effective date (mm/yyyy): ____ / _____

continued ➤

What is the name of your current or prior dental insurance carrier? _____

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).

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 insurance carrier?
If yes, please provide the name of the company or group: _____

Section 4 Plan 65 Select F Disclosure Statement

If applying for Select F, by signing this application I certify I have received the following information and understand the restrictions of the Plan 65 Select F benefit plan I have chosen.

- An outline of coverage comparing the Plan 65 Select F benefit plan I have chosen with all Plan 65 benefit plans offered by Blue Cross & Blue Shield of Rhode Island (BCBSRI)
- A listing of the Plan 65 Select F hospital network
- A description of benefits, coinsurance, and deductibles applicable when Plan 65 Select F 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 F non-participating hospitals
- A description of my right to purchase any other Medicare Supplement contract offered by BCBSRI

Section 5 Dental Direct Disclosure Statement

DENTAL DIRECT IS NOT A MEDICARE SUPPLEMENT INSURANCE PLAN.

- A 12-month waiting period applies to major restorative services and surgical periodontics. If you decide to cancel or change your coverage, you must wait 12 months to re-apply.
- If you re-apply, you must wait an additional 12 months for major restorative coverage and surgical periodontics.

Section 6 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.

SIGN HERE ☞

Signature of Applicant Date

If you are the authorized representative*, you must *sign on the next page and* provide the required information.

*An Authorized Representative is a person you choose to assist you with Medicare-related matters, such as:

- Choosing a plan to participate in
- Gathering more information about your insurance plan/policies for research and decision making purposes
- Handling claims and/or payments
- Receiving a notice in connection with an appeal on your behalf, and reviewing/submitting personal medical information when working with associated appeals

Authorized Representative's Signature	
Name:	Phone Number: ( ) _____ – _____
Address:	Relationship to Enrollee:

Section 7 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)

MEMBERSHIP USE ONLY

Name of staff member/agent/broker (if assisted in enrollment) _____

Broker ID _____ Plan ID _____ Effective Date of Coverage _____

New _____ Tocnv _____ Other _____

INTERNAL USE ONLY

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

Complete date _____ Initial _____

Blue Cross Blue Shield of Rhode Island

www.bcbsri.com

500 Exchange Street • Providence, RI 02903-2699

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