MedigapSecurity

EMPLOYER GROUP ENROLLMENT FORM

Please contact MedigapSecurity if you need information in another language or format (Braille).

Easy step-by-step instructions for filling out this MedigapSecurity enrollment form.

SECTION A Personal Information — Provide the personal information requested. Then, check the box(es) in front of your requested action and provide information about your employer or union.

SECTION B Medicare Insurance Information — Use your Medicare card to complete this section.

SECTION C Declaration

SECTION D Notice Regarding Fraudulent Information

SECTION E General Information

SECTION F Important Questions — Please answer the questions in this section.

SECTIONS G&H Please read the information provided.

SECTION I Your Signature — Please read the information provided, then sign and date your enrollment form. If you are an authorized representative, please provide the information requested.

QUESTIONS?

Call toll-free 1-866-319-5777
Speech- or hearing-impaired: 711
Seven days a week, 8 a.m. to 8 p.m.
www.ibxmedicare.com

Benefits underwritten or administered by Independence Blue Cross and Highmark Blue Shield — independent licensees of the Blue Cross and Blue Shield Association.

MedigapSecurity

GROUP COVERAGE APPLICATION FORM

Benefits underwritten or administered by Independence Blue Cross and Highmark Blue Shield – independent licensees of the Blue Cross and Blue Shield Association.

A TO APPLY FOR MEDIGAPSECURITY. . .

Check plan option, which is available through your group. If you are unsure of your options, please contact your group:

☐ Plan A ☐ Plan B ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan F High Deductible

☐ Plan G ☐ Plan G High Deductible ☐ Plan N

Desired effective date: _____

LAST Name:	FIRST Name:	Middle Initial:	☐ Mr. ☐ Mrs. ☐ Ms.
Phone Number: ☐☐☐-☐☐☐-☐☐☐☐			Sex: ☐ M ☐ F
Birth Date: ☐☐-☐☐-☐☐☐☐	Age:	Social Security #: [☐☐☐-☐☐-☐☐☐☐]	
Permanent Residence Street Address:			
City:	State:	ZIP Code:	

Mailing Address (only if different from your Permanent Residence Address):

Street Address: City: State: ☐☐ ZIP Code: ☐☐☐☐☐

Emergency Contact:

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ **Relationship to You:**

Email Address (optional): _____

By giving us your email address and providing your signature in the designated box, you are providing permission for us to contact you with information related to your health benefits, additional products, services and/or educational information related to your health care. Providing your email address is optional.

B PLEASE PROVIDE YOUR MEDICARE INSURANCE INFORMATION

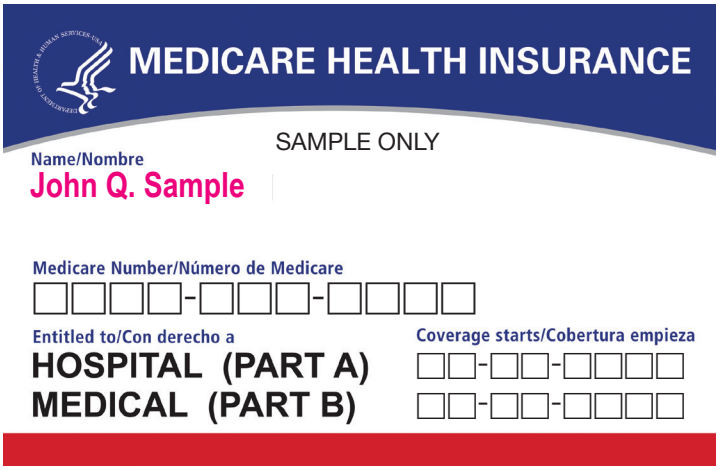
Please take out your Medicare card to complete this section.

- Please fill in these blank boxes so they match your red, white, and blue Medicare card.

– OR –

- Attach a copy of your Medicare card or your letter from the Social Security Administration or Railroad Retirement Board.

You must have Medicare Part A and Part B to join MedigapSecurity.



C DECLARATION

By signing section I of the application, I elect coverage under the plan specified in section A of the form and for the persons listed there, and agree to abide by the conditions of the agreement and pay required premiums for the plan as selected. I hereby authorize any licensed physician, medical or medically related facility, insurance company, or other organization or person or institution that has any records concerning my health or the health of any covered family member to forward such information to Independence Blue Cross and Highmark Blue Shield. This application is subject to acceptance and to the waiting periods, exclusions, and all other provisions contained in the agreement between my Employer, Association, or Welfare board, and Independence Blue Cross and Highmark Blue Shield.

D NOTICE REGARDING FRAUDULENT INFORMATION

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 subjects such person to criminal and civil penalties.

E GENERAL INFORMATION

Various Medicare Secondary Payer (MSP) laws place responsibilities on certain employers that may affect the rights of employees, retirees, and/or their dependents who are eligible for Medicare. These MSP laws, in general, speak of certain persons who are age 65 or older or certain persons who are disabled. If you have any questions about the MSP laws, please contact your employer.

F PLEASE ANSWER THE FOLLOWING QUESTIONS

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you are eligible for guaranteed issue of a Medicare supplement insurance policy, or that you have certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS.

Please mark Yes or No below with an X.

To the best of your knowledge:

1. Did you turn age 65 in the last 6 months? ☐ Yes ☐ No
2. Did you enroll in Medicare Part B in the last 6 months? ☐ Yes ☐ No
   If yes, what is the effective date? ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)
3. 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, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
   Do you receive any benefits from Medicaid OTHER THAN payments towards your Medicare Part B premium? ☐ Yes ☐ No
4. If you had coverage from any Medicare plan other than Original Medicare within the last 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.

   START ☐☐-☐☐-☐☐☐☐ (MM DD YYYY) **END** ☐☐-☐☐-☐☐☐☐ (MM DD YYYY)

   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
   Was this your first time in this type of Medicare plan? ☐ Yes ☐ No
   Did you drop a Medicare supplement policy to enroll in the Medicare Plan? ☐ Yes ☐ No
5. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
   If yes, with what company and what plan do you have? _____
   If yes, do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

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

If yes, Insurance Company name: _____ Insurance Company ID #: _____

Group #: _____ What kind of policy? _____

Start Date: _____ End Date: _____

G IMPORTANT – PLEASE READ CAREFULLY

Independence Blue Cross and Highmark Blue Shield MedigapSecurity Medicare Supplement Programs – Plans A, B, C, D, F, F High Deductible, G, G High Deductible, and N are available to individuals who enroll during their "Open Enrollment Period."

You do not need more than one Medicare supplement policy.

If you purchase this 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.

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 the Medicare supplement policy 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 suspension.

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 suspension.

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).

H GUARANTEED ISSUANCE

Guaranteed Issue For Eligible Persons Under the Balanced Budget Act of 1997: The federal government created the Medicare Advantage Program to increase the health care options for Medicare-eligible individuals beyond basic Medicare and Medicare health maintenance organizations (HMOs). This law requires insurance companies (including Independence Blue Cross and Highmark Blue Shield) to offer you certain Medicare supplemental plans on a guaranteed issue basis; that is, they cannot refuse to cover you, when you are ending your enrollment in another plan under specific circumstances, as follows:

(1) You are enrolled under an employee welfare benefit plan that (a) provides health benefits that supplement Medicare; and the plan terminates, **or** the plan ceases to provide all supplemental Medicare health benefits to you; **or** (b) is primary to Medicare and the plan terminates, **or** the plan ceases to provide health benefits to you because you left the plan.

(2) You are enrolled in a Medicare Advantage plan and any of the following circumstances apply, **or** you are 65 years of age or older and enrolled in a Program of All-Inclusive Care for the Elderly (PACE), and there are circumstances that permit discontinuance of your enrollment with the provider including, but not limited to, the certification of the organization or plan was terminated; the organization has terminated or otherwise discontinued providing the plan in the area in which you reside; you are no longer eligible to elect the plan because of a change in your place of residence, the organization offering the plan substantially violated a material provision of the contract; or the organization materially misrepresented the plan's provisions in marketing the plan to you.

H GUARANTEED ISSUANCE (CONTINUED)

(3) You are enrolled in a Medicare cost contract or similar organization, or health care prepayment plan or Medicare Select plan, and there are circumstances that permit discontinuance of your enrollment with the provider including, but not limited to, the certification of the organization or plan was terminated; the organization has terminated or otherwise discontinued providing the plan in the area in which you reside; you are no longer eligible to elect the plan because of a change in your place of residence, the organization offering the plan substantially violated a material provision of the contract; or the organization materially misrepresented the plan's provisions in marketing the plan to you.

(4) You are enrolled in a Medicare Supplement policy and coverage discontinues due to insolvency or other involuntary termination of coverage or enrollment under the policy; or the issuer of the policy substantially violated a material provision of the policy; or the issuer, producer or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to you.

(5) You were enrolled in a Medicare supplemental plan and terminate enrollment and subsequently enroll in, for the first time, any Medicare Advantage plan, any Medicare cost contract, any Medicare SELECT plan, or any Program of All-Inclusive Care for the Elderly (PACE) provider, and the subsequent enrollment under this paragraph is terminated by the enrollee during the first 12 months of the subsequent enrollment.

(6) You, upon first becoming eligible for benefits under Part A and enrolled in Part B, if eligible, of Medicare, enroll in a Medicare Advantage plan or with a PACE provider, and disenrolls from the plan or program within 12 months after the effective date of enrollment.

(7) You enrolled in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, were enrolled under a Medicare Supplement policy that covers outpatient prescription drugs and you terminated enrollment in the Medicare Supplement policy and submit evidence of enrollment in Medicare Part D along with the application for a Medicare supplement policy that has a benefit package classified as Plan A, B, C, F, F High Deductible, K or L, and that is offered and is available for issuance to new enrollees by the same issuer that issued your Medicare supplement policy with outpatient prescription drug coverage.

I PLEASE READ AND SIGN BELOW

I hereby apply for the policy coverage specified in section A. I understand that this application is subject to your acceptance and to the conditions and exclusions contained in the agreement. I agree to pay charges for these coverages as billed. I am covered by Medicare Part A and Part B.

I acknowledge and agree that any personally identifiable health information about me ("Protected Health Information") is protected by The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Independence Blue Cross and/or Highmark Blue Shield may use and disclose Protected Health Information for payment, treatment, and health care operations as described in its Notice of Privacy Practices. I understand that a copy of Independence Blue Cross and/or Highmark Blue Shield's Notice of Privacy Practices is available at ibxmedicare.com.

I understand that the Independence Blue Cross/Highmark Blue Shield MedigapSecurity policy that I am applying for has a preexisting condition provision. Under this provision, benefits related to any preexisting condition will not be provided for six months after I enroll in MedigapSecurity. I also understand, however, that the preexisting condition provision will not apply to these benefits if, when I enroll in MedigapSecurity, I have already satisfied a preexisting condition provision for the benefits under another Medicare supplement policy or the preexisting condition provision is waived because I am an "eligible person" as defined by federal and Pennsylvania laws and regulations.

If I was previously enrolled under another Blue Cross® and Blue Shield® policy or a Medicare supplement policy with another company with a preexisting condition limitation, coverage under this policy for a preexisting condition limitation will only be excluded to the extent of the time that I did not satisfy the preexisting condition exclusion period under the previous policy and in no event shall such preexisting condition exclusion exceed six (6) consecutive months from the effective date of my coverage under this policy.

"Preexisting Condition" means a disease or physical condition for which medical advice or treatment has been received by me within one hundred eighty (180) days immediately prior to my initial effective date under this agreement or any endorsement made part of this policy.

I understand that I can find complete details of the program(s) in the policy, which I will receive after I return this application form.

I PLEASE READ AND SIGN BELOW (CONTINUED)

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the state where the individual resides) on this application means that I have read and understand the contents of this application. If signed by an authorized individual, this signature acknowledges that: 1) this person is authorized under state law to complete this application and 2) documentation of this authority is available upon request by Independence Blue Cross and Highmark Blue Shield or by Medicare.

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 subjects such person to criminal and civil penalties.

Benefits underwritten or administered by Independence Blue Cross and Highmark Blue Shield – independent licensees of the Blue Cross and Blue Shield Association.

I acknowledge receiving: (a) an Outline of Coverage for the policy applied for, and

(b) a "Guide to Health Insurance for People with Medicare."

Your Signature: _____

Today's Date: ☐☐-☐☐-☐☐☐☐

FOR OFFICE USE ONLY		
IDENT. No.		
GR NO	TR DT	REAS
BC EFF	PR ST	ORIG
BS EFF	TC	

J TO BE COMPLETED BY GROUP ADMINISTRATOR

Is enrollee full-time employee? ☐ Yes ☐ No How many active employees are in your group? _____

Employer: _____ Group # _____

Employer's Address: _____ Phone #: _____

If you are the authorized representative, you must provide the following information:

Name: _____

Address: _____

Phone Number: ☐☐☐-☐☐☐-☐☐☐☐ Relationship to Applicant: _____

[1901 Market Street, Philadelphia, PA 19103-1480]

MedigapSecurity is not connected with or endorsed by the U.S. government or the federal Medicare program.

Independence Blue Cross Highmark Blue Shield

Independence Blue Cross and Highmark Blue Shield are independent licensees of the Blue Cross and Blue Shield Association.

K AGENT'S CERTIFICATION

The undersigned Agent certifies that the Applicant has read, or had read to the Applicant, the completed application and that the Applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

TO BE COMPLETED BY AGENT (Attach separate sheet, if necessary)

1. List any other health insurance policy you have sold the Applicant that is still in force.

_____

_____

_____

_____

2. List any other health insurance policy you have sold the Applicant in the past five (5) years that is no longer in force.

_____

_____

_____

_____

I certify that:

1. I have accurately recorded the information supplied by the Applicant; and
2. I have given an Outline of Coverage for the policy applied for and a Guide to Health Insurance for People with Medicare to the Applicant.

_____ _____

Agent's Signature: Date:

_____ _____

Agent's Printed Name: Agent No:

MedigapSecurity
[1901 Market Street
Philadelphia, PA 19103-1480]

MedigapSecurity

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MedigapSecurity

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage and replace it with a policy to be issued by Independence Blue Cross and Highmark Blue Shield. 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 coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, PRODUCER (OR OTHER REPRESENTATIVE):

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

☐ **Additional benefits**

☐ **No change in benefits, but lower premium**

☐ **Fewer benefits and lower premiums**

☐ **My plan has outpatient prescription drug coverage, and I am enrolling in Part D.**

☐ **Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:**

☐ **Other. (please specify)** _____

_____

_____**: Signature of Producer or other representative**

_____**: Applicant Signature and Date**

1. Health conditions that you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.
3. Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Language Assistance Services

Spanish: ATENCIÓN: Si habla español, cuenta con servicios de asistencia en idiomas disponibles de forma gratuita para usted. Llame al 1-800-275-2583 (TTY: 711).

Chinese: 注意：如果您讲中文，您可以得到免费的语言协助服务。致电 1-800-275-2583。

Korean: 안내사항: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-275-2583 번으로 전화하십시오.

Portuguese: ATENÇÃO: se você fala português, encontram-se disponíveis serviços gratuitos de assistência ao idioma. Ligue para 1-800-275-2583.

Gujarati: સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. 1-800-275-2583 કૉલ કરો.

Vietnamese: LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi sẽ cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho bạn. Hãy gọi 1-800-275-2583.

Russian: ВНИМАНИЕ: Если вы говорите по-русски, то можете бесплатно воспользоваться услугами перевода. Тел.: 1-800-275-2583.

Polish UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-800-275-2583.

Italian: ATTENZIONE: Se lei parla italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-800-275-2583.

Arabic:
ملحوظة: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك بالمجان. اتصل برقم 1-800-275-2583.

French Creole: ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 1-800-275-2583.

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga serbisyo na tulong sa wika nang walang bayad. Tumawag sa 1-800-275-2583.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique-vous sont proposés gratuitement. Appelez le 1-800-275-2583.

Pennsylvania Dutch: BASS UFF: Wann du Pennsylvania Deitsch schwetzscht, kannscht du Hilf griege in dei eegni Schprooch unni as es dich ennich eppes koschte zellt. Ruf die Nummer 1-800-275-2583.

Hindi: ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। कॉल करें 1-800-275-2583।

German: ACHTUNG: Wenn Sie Deutsch sprechen, können Sie kostenlos sprachliche Unterstützung anfordern. Wählen Sie 1-800-275-2583.

Japanese: 備考：母国語が日本語の方は、言語アシスタンスサービス（無料）をご利用いただけます。1-800-275-2583へお電話ください。

Persian (Farsi):
توجه: اگر فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما فراهم می باشد. با شماره 1-800-275-2583 تماس بگیرید.

Navajo: Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh. Hódíílnih kojį' 1-800-275-2583.

Urdu:
توجہ درکارہے: اگر آپ اردو زبان بولتے ہیں، تو آپ کے لئے مفت میں زبان معاون خدمات دستیاب ہیں۔ کال کریں 1-800-275-2583.

Mon-Khmer, Cambodian: សូមមេត្តាចាប់អារម្មណ៍៖ ប្រសិនបើអ្នកនិយាយភាសាមន-ខ្មែរ ឬភាសាខ្មែរ នោះជំនួយផ្នែកភាសានឹងមានផ្តល់ជូនដល់លោកអ្នកដោយឥតគិតថ្លៃ។ ទូរសព្ទទៅលេខ 1-800-275-2583។

Discrimination is Against the Law

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters, and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact our Civil Rights Coordinator. If you believe that This Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator. You can file a grievance in the following ways: In person or by mail: ATTN: Civil Rights Coordinator, 1901 Market Street, Philadelphia, PA 19103, By phone: 1-888-377-3933 (TTY: 711) By fax: 215-761-0245, By email: civilrightscoordinator@1901market.com. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.