Independence

Independence Blue Cross is an independent licensee of the Blue Cross and Blue Shield Association.

1901 Market Street, Philadelphia, PA 19103-1480

# GROUP APPLICATION FORM FOR RETIREE 65 PLUS COVERAGE

## 1. LIST PERSON(S) TO BE COVERED UNDER RETIREE 65 PLUS:

(To be eligible for Retiree 65 Plus you must be covered by Medicare Parts A & B)

Name (Last, First, Middle Initial)

Social Security # | Date of Birth

Spouse's Name (Last, First, Middle Initial)

Spouse's Social Security # | Date of Birth

Address | Phone # ( )

City, State, Zip , ,

**FOR OFFICE USE ONLY**

IDENT. #

GROUP #

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OMD | B.S.
EFF

S | ORIG

## 2. FROM YOUR MEDICARE CARD, GIVE:

Medicare Claim # _____ Effective Date of Hospital Insurance _____ Effective Date of Medical Insurance _____

## 3. FROM YOUR SPOUSE'S MEDICARE CARD, GIVE:

Medicare Claim # _____ Effective Date of Hospital Insurance _____ Effective Date of Medical Insurance _____

## 4. CHECK COVERAGE DESIRED AND AVAILABLE THROUGH YOUR GROUP:

☐ Independence Retiree 65 Plus (To be eligible you must have Medicare Hospital and Medicare Medical Insurance)

## 5a. IF YOU ARE PRESENTLY ENROLLED IN BLUE CROSS/BLUE SHIELD, GIVE:

| Name of Plan | Plan Location (City, State) | ID or Policy # |
|---|---|---|
| | | |

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## 5b. LIST BELOW MEMBERS PRESENTLY ON CONTRACT WHO ARE NOT ELIGIBLE FOR MEDICARE:

| Name | Social Security # | Sex | Date of Birth M. | Date of Birth D. | Date of Birth YR. | Check Relationship |
|---|---|---|---|---|---|---|
| | | | | | | ☐ Husband ☐ Wife |
| | | | | | | ☐ Child ☐ Stepchild |

## 6. PRIOR INSURER: (Take information from your ID card.)

Insurance Company Name: _____

Insurance Company ID #: _____ Group #: _____

## 7. PLEASE READ THE REVERSE SIDE OF THIS FORM, THEN SIGN AND DATE BELOW:

The information supplied on this application is accurate and complete to the best of my knowledge, and I have read and agree to the terms set forth on the reverse side of the form.

**SIGN HERE:** _____ **DATE:** _____

Signature of Applicant

## 8. 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 #: _____

## *IMPORTANT — Please read carefully*

### 9. DECLARATION

By signing the reverse side of the application, I elect coverage under the plan specified on the reverse side 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. 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.

### 10. 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.

### 11. GENERAL INFORMATION

Various Medicare Secondary Payor (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, of certain persons who are disabled, and of certain persons who suffer from end-stage renal disease. If you have any questions about the MSP laws, please contact your employer.

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