Horizon

Horizon Blue Cross Blue Shield of New Jersey

Application for Medicare Supplement Insurance for Individuals 65+

Policies are issued by Horizon Insurance Company, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

APPLICATION INSTRUCTIONS:

1. Please PRINT IN INK.
2. Please complete all sections as they apply to you.
3. If this application is replacing a previous Medicare supplement insurance policy, or Medicare Advantage coverage, please sign the Replacement Notice, Section 8 and return.
4. Please read Section 4 regarding important information concerning your application.
5. Be sure to sign the application.
6. Do not send money with this application – you will be billed later.

1 CUSTOMER INFORMATION

Last Name

First Name

MI

Date of Birth

MM DD YYYY

Age

Sex

M F

Social Security Number

Street Address or Box Number

City

State

Zip Code

Telephone Number (include area code)

Horizon Blue Cross Blue Shield of New Jersey ID # (if any)

Medicare Information:

You **must** be age 65 or older and enrolled in Medicare Parts A and B. Please fill in these blanks so they match your red, white and blue Medicare Card.

Medicare Claim Number

(copy from your Medicare ID Card)

Hospital Insurance (Part A) Effective Date

MM DD YYYY

Medical Insurance (Part B) Effective Date

MM DD YYYY

2 PAYMENT SCHEDULE (Choose One) - SEND NO MONEY NOW

☐ Monthly ☐ Quarterly (3 months) ☐ Semi-Annually (6 months)

HM11171 (W0913)

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Medigap plans are underwritten by Horizon Insurance Company, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ). Both companies are Independent licensees of the Blue Cross and Blue Shield Association. Communications are issued by Horizon BCBSNJ in its capacity as administrator of programs and provider relations for all of its companies.

3 PLEASE ENROLL ME IN THE FOLLOWING HORIZON STANDARDIZED MEDICARE SUPPLEMENT BENEFIT PLANS:

☐ Plan A ☐ Plan C ☐ Plan F ☐ Plan G ☐ Plan K ☐ Plan N

4 PLEASE READ THIS IMPORTANT INFORMATION REGARDING YOUR MEDICARE SUPPLEMENT APPLICATION

A. You do not need more than one Medicare supplement policy.

B. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

C. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

D. 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 were 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.

E. 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 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 be substantially equivalent to your coverage before the date of suspension.

F. Counseling services are available in New Jersey to provide advice concerning your purchase of Medicare supplement coverage 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).

PLEASE READ THE IMPORTANT INFORMATION IN SECTION 5 BELOW

5 GUARANTEED ACCEPTANCE AND GUARANTEED ISSUANCE

Guaranteed Acceptance

If you are eligible to apply, your acceptance into any Standardized Medicare Supplement Benefit Plan listed in Section 3 is guaranteed at any time throughout the year.

If you submit your application prior to or during your Medigap open enrollment period (the 6-month period beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B) and had a continuous period of creditable coverage of at least six months, Horizon Insurance Company will not exclude benefits based on a preexisting condition.

Guaranteed Issue

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying 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 have a guaranteed issue right to enroll in one or more of the Standardized Medicare Supplement Benefit Plans listed in Section 3 without a preexisting condition limitation. You are required to:

- Apply within the required time period following the termination of your prior health insurance plan.
- Provide a copy of the termination notice you received from your prior insurer with your application, which verifies the circumstances of your prior plan's termination and describe your right to guaranteed issue of Medicare supplement insurance.

PLEASE ANSWER ALL QUESTIONS in Section 6.

6 OTHER HEALTH INSURANCE INFORMATION – MUST BE COMPLETED

Unless noted differently, the following questions should be answered yes or no.

To the best of your knowledge:

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? ☐☐☐☐☐☐☐☐
   MM DD YYYY

2. (a) Are you covered for medical assistance through the State Medicaid program?
   (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. ☐ Yes ☐ No

   (b) If yes,
   i. Will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No
   ii. 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 plan other than original Medicare within the past 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, please provide your desired end date.

   START ☐☐☐☐☐☐☐☐ END ☐☐☐☐☐☐☐☐
   MM DD YYYY MM DD YYYY

   (b) 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

   (c) Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

   (d) Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

4. (a) Do you have another Medicare supplement policy in force? ☐ Yes ☐ No
   (b) If so,
   (i) With what company and what plan do you have?

   (ii) Do you intend to replace your current Medicare supplement policy with this policy?

   ☐ Yes ☐ No

6 OTHER HEALTH INSURANCE INFORMATION – MUST BE COMPLETED (CONTINUED)

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

   (b) If so, with what company and what kind of policy?

   (c) What are your dates of coverage under the other policy? If you are still covered under the other policy, please provide your desired end date.

   START ________ MM DD YYYY   END ________ MM DD YYYY

7 Authorization Section – Must be Completed

I understand that: (a) my Medicare Supplement policy will not be effective before the date I am enrolled under both parts A and B of the Medicare Program; (b) if I omit or falsify any statement in this application, the Plan can cancel this policy; (c) my policy, if issued, will cover only me; and (d) my policy does not cover any pre-existing conditions until six (6) months after the effective date of coverage.

I certify that I am a permanent resident in New Jersey. Also, I agree that any physician, hospital, or other provider is authorized to give the Plan required information about my medical history.

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Signature ____________________   Date __________

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

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

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage coverage and replace it with a policy to be issued by Horizon Insurance Company. Your new policy provides thirty (30) days within which you may decide without cost whether you desire to keep the coverage.

You should review this new 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 HORIZON INSURANCE COMPANY

We have reviewed your current medical or health insurance coverage. To the best of our 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 (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 Medicare Part D

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

☐ other (please specify)

1. Health conditions that you may presently have (pre-existing 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 may have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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.

   Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

____
Signature of Agent, Broker or Other Representative

____ ______________________
Applicant Signature Date

Agent Use Only:

GA ID: GA Receipt Date: _____/_____/_____ NPN#

Name of broker: ______________________________ Receipt Date: _____/_____/_____

(Selling Agent) Phone #: ______________________________ Effective Date: _____/_____/_____

Agent ID: ________________ Opportunity ID: ______________ Activity ID: ______________

Consumer ID: ______________ Mode: ______________ Coverage Code: ______________

Continuation of Coverage Date: _____/_____/_____ Microfilm Date: _____/_____/_____