



Last Name	Jr., Sr., etc.	First Name	MI
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Social Security Number

## SECTION 2 – HEALTH QUESTIONS

If you are applying during a Medigap Open Enrollment Period or a Guaranteed Issue Period (refer to “Choosing a Medigap Policy” at [bcbstmedicare.com/medigap](http://bcbstmedicare.com/medigap) for clarification), SKIP SECTION 2 and GO TO SECTION 3.

Have you used tobacco in any form in the past 12 months?  Yes  No

Tobacco usage includes the use of any tobacco products (such as cigarettes, cigars, pipes and smokeless tobacco) as well as electronic nicotine delivery systems (including e-cigarettes and vaping devices).

Do any of the following questions apply to you?

Yes  No If you answered “Yes,” the applicant does not qualify for this insurance.

BlueCross may take steps to verify your responses.

1. Within the past **ten (10) years**, have you been treated for or had a medical provider diagnose you with Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?
2. Within the past five **(5) years**, have you been treated for or had a medical provider diagnose you with or recommend treatment, surgery or prescription medicine for:
  - a. Cancer (excluding basal or squamous cell), Hodgkin’s disease, leukemia or melanoma — even if the conditions are in remission?
  - b. Congestive heart failure (also called CHF), coronary artery disease, angina, peripheral vascular disease, circulatory disorder (excluding high blood pressure), heart disease, enlarged heart, transient ischemic attack (TIA), stroke, heart or heart valve surgery, angioplasty, coronary bypass, pacemaker, defibrillator or stent placement?
  - c. Blood disorders such as hemophilia, blood clots or anemia requiring repeated blood transfusion or any other blood disorder?
  - d. Uncontrolled or insulin dependent diabetes, amputation or eye disease due to diabetes, chronic cystitis, Addison’s disease, liver disease, kidney failure, nephritis, hepatitis, renal insufficiency or kidney dialysis or gangrene?
  - e. Emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), or any chronic pulmonary disease requiring the use of oxygen?
  - f. Paget’s disease, rheumatoid or disabling arthritis, lupus, osteoporosis with fracturing, or other bone or connective tissue disorder?
  - g. Mental or nervous disorder requiring treatment, organic brain disorder, Alzheimer’s disease, ALS (Lou Gehrig’s disease), muscular dystrophy (MD), myasthenia gravis, Parkinson’s disease, multiple sclerosis (MS), cerebral palsy, epilepsy, neuropathy, paralysis, senile dementia or other senility disorders, or alcohol or drug abuse?
3. Within the past **two (2) years** have you been admitted to a hospital three (3) or more times?
4. Are you permanently living in a nursing facility, permanently bedridden or using a wheelchair?

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**SECTION 3 – CURRENT OR PREVIOUS HEALTH INSURANCE**

If you lost or are losing other health insurance coverage and got a notice from your old 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 be guaranteed acceptance in one or more 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. 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
  - c. If yes, what is the effective date? \_\_\_\_\_
2. 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,"**
  - a. Will Medicaid pay your premiums for this Medicare Supplement policy?  Yes  No
  - b. 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, leave "End Date" blank.  
 Beginning Date (mm/dd/yyyy): \_\_\_\_\_ End Date (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, with what company, and what plan do you have? \_\_\_\_\_
  - c. If so, do you intend to replace your current Medicare Supplement policy with this policy?  Yes  No  
**If "Yes", please attach a copy of the Replacement Notice included in your enrollment package.**
5. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)  Yes  No
  - a. If so, with what company and what kind of policy? \_\_\_\_\_
  - b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "End Date" blank.)  
 Beginning Date (mm/dd/yyyy): \_\_\_\_\_ End Date (mm/dd/yyyy): \_\_\_\_\_
  - c. Was the loss of coverage voluntary?  Yes  No



