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" blank. Start __/__/__ End __/__/__

   (b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplemental policy? ❑ Yes ❑ No

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

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

4. (a) Do you have another Medicare supplemental 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 supplemental policy with this policy? ❑ Yes ❑ No

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

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

   _____

   _____

   (b) What are your dates of coverage under the other policy? Start __/__/__ End __/__/__ (If you are still covered under the other policy, leave "END" blank.)

I hereby acknowledge I have been informed that my Medex Choice Policy shall not restrict payment for covered services provided by non-network providers if both of the following conditions exist: (a) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or a condition; and (b) It is not reasonable to obtain services through an HMO Blue Network Provider. I also understand that to be eligible to receive Medex Choice coverage, I must choose an HMO Blue PCP and receive all my care from HMO Blue Network Providers, except when both of the two conditions above exist.

I certify that the statements made and answers given are complete and true. I have read and carefully considered all of the "Important Information" on this form. I also certify that I received the *"Outline of Medicare Supplement Coverage."* I understand that no health care provider, or private or government agency may sponsor, purchase, or contribute to the cost of this Medex plan. For the purpose of processing this application, for 30 months from the date this authorization is signed, and if I enroll in coverage, for as long as I am covered, I understand that all of my health care providers, other insurance companies, or my employer are authorized to release all of my medical records and other information to Blue Cross and Blue Shield of Massachusetts representatives for the purpose of determining my coverage and administering my benefits. I or my authorized representative is entitled to receive a copy of this authorization form. I understand that the benefits for which I am eligible are those described in the applicable Medex® Subscriber Certificate. I understand that Medex benefits and premium rates are subject to change as allowed by state law. I understand that enrollment in this plan is contingent upon payment of premium.

Applicant's Signature: _____ Date: _____

MASSACHUSETTS

182761 GCC/IBT-348-C 42-0435-18 (3/18)

MASSACHUSETTS

Medex®

Application for Direct Billed Medex®´ Choice

Directions

Medex Choice requires applicants to select a primary care provider (PCP). Please go to **www.bluecrossma.com/findadoctor** to choose your Medex Choice PCP and add this information, along with the PCP ID number, to this application. You will also find the provider's PCP ID number within the Find A Doctor tool. If you need help choosing a PCP or finding the PCP ID number, please call **1-800-258-2226** (TTY: **711**), Monday through Friday, 8:00 a.m. to 6:00 p.m.

- Please print clearly.
- Please carefully read and answer all questions. Incomplete applications will not be accepted. Please keep a copy of the application for your records.
- Please do not send us your application until you have received your red, white, and blue Medicare card.
- Do not send money with this application. You will receive a bill when payment is due.
- Please complete and return the white copy to:

  Direct Sales
  Blue Cross Blue Shield of Massachusetts
  One Enterprise Drive
  Quincy, MA 02171-1753

  Or fax the application to **1-617-246-3633**
- To enroll by phone, please call **1-800-678-2265**.
- Medex premium rates and benefits are explained in the booklet you received with this application. If you need more information or assistance, call us at **1-800-678-2265**.
- For all other questions, contact:

  Medex Member Service: 1-800-258-2226
  TTY: 711

You are eligible to apply for a Medex plan if you meet all of the following requirements:

- You are a resident of Massachusetts and you actually live in Massachusetts.
- You are eligible for Medicare Part A and Medicare Part B and enrolled in Medicare Part B.
- If you are under age 65, you qualify for Medicare coverage because of disability except for end-stage renal disease.

Note: If you are covered by Medicaid, you may or may not be eligible to enroll in Direct Billed Medex. See paragraph (f) of the "Important Information" section of this application form.

Please answer all questions.

In order to enroll in this plan, you must select a PCP

Name of PCP | City | State | Zip

PCP ID# | Current PCP? ❑ Yes ❑ No

Your Social Security Number:

_____ - _____ - _____

How often would you like to be billed?

❑ Monthly ❑ Quarterly

Would you like your premium payment due on the 1st of the month or the 15th of the month?

❑ 1st of the month ❑ 15th of the month

First Name | Last Name | Middle Initial

Your gender

❑ Male ❑ Female

Your complete date of birth:

Your telephone number:

( ) –

Your permanent home address:

Number and Street | City | State | Zip

If you want your Medex bill sent to an address other than your home address, complete the following section.

Your billing address only:

Number and Street | City | State | Zip

Medicare Insurance Information

Please copy information from your red, white, and blue Medicare card in the spaces below.
Medicare Number:

Medicare Part A (Hospital Insurance) Effective Date:

Medicare Part B (Medical Insurance) Effective Date:

If you are under age 65, what is your disability that qualifies you for Medicare coverage?

Are you currently a Blue Cross Blue Shield of Massachusetts member? ❑ Yes ❑ No
If yes, give your Blue Cross Blue Shield identification number:

Important Information

Please read the "Important Information" section. Then answer questions 1 through 5 on page 3.

(a) You do not need more than one Medicare supplemental insurance policy.

(b) If you purchase this Policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.

(c) You may be eligible for Medicaid benefits and may not need a Medicare supplemental insurance policy.

(d) The benefits and premiums under your Medicare supplemental insurance 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 Policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.

If the Medicare supplemental insurance 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, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

(e) If you are eligible for, and have enrolled in a Medicare supplemental insurance 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 supplemental insurance policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplemental insurance policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplemental insurance 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 supplemental insurance 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, as you will be enrolled in the most comparable plan without outpatient prescription drug coverage.

(f) Counseling services are available in Massachusetts to provide advice concerning your purchase of Medicare supplemental Insurance policy 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). You may call the Massachusetts Executive Office of Elder Affairs insurance counseling program at **1-800-243-4636** (TTY: **1-800-872-0166**) or write to that office at the following address for more information: One Ashburton Place, 5th Floor, Boston, MA 02108.

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 supplemental 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 supplemental 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? [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

   If yes,

   (a) Will Medicaid pay your premiums for this Medicare supplemental policy? ❑ Yes ❑ No
   (b) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ Yes ❑ No