

Wellmark Blue Cross and Blue Shield of South Dakota is an Independent Licensee of the Blue Cross and Blue Shield Association.

A. Tell us about yourself.

Requested Effective Date ____/____/____	Group Billing Unit <i>for Wellmark use only</i>
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Applicant Name (<i>First, Middle, Last</i>)		
Date of Birth (<i>mm/dd/yyyy</i>) ____/____/____	Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Social Security No.
Daytime Phone ()	E-mail Address (optional)	
Mailing Address (Include Street, PO Box, Bldg Name/No., Apt. No.)		County Name
City	State	Zip

Yes No **A1.** Are you a Farm Bureau Member? If yes, please provide the following:

Farm Bureau Member Number _____

Farm Bureau County Number _____

Yes No **A2.** Have you used tobacco during the 12 months immediately preceding the effective date of this application?

Yes No **A3.** Are you applying to reinstate a policy that had been previously suspended?

Payer's Billing Information (if different from Applicant) Payer Name:		
Payer's Mailing Address (Street, Bldg Name/No., Apt. No.)		PO Box
City	State	Zip

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B. Provide us with your Medicare information (as shown on your Medicare ID Card).

B1. Health Insurance Claim No. (Medicare ID No.): Alpha Letter

B2. Hospital Insurance (Part A) Effective Date: (month/day/year) _____/_____/_____

B3. Medical Insurance (Part B) Effective Date: (month/day/year) _____/_____/_____

C. Answer the following questions to determine if your acceptance is guaranteed.

Yes No **C1.** Did you turn age 65 in the last 6 months?

Yes No **C2.** Did you enroll in Medicare Part B in the last 6 months?
If yes, what is your Part B effective date? _____/_____/_____

If you answer **YES** to the following question, you are within your Medicare Supplement Open Enrollment period and your acceptance is guaranteed:

Yes No **C3.** Will your plan effective date be within 6 months after enrolling in Medicare Part B **OR** turning age 65?

If you answer **YES** to the following question, your acceptance may be guaranteed if you are losing other health coverage:

Yes No **C4.** Have you lost or are losing other health insurance coverage and received a notice from your previous insurer stating that you were eligible for guaranteed issue of a Medicare supplement insurance policy, or that you had certain rights to buy such a policy? If yes, please include a copy of the notice from your previous insurer with your application.

STOP
If you qualify for guaranteed acceptance, you are eligible for Plans A, D, F, High Deductible F and N. To determine your monthly premium amount, refer to the MedicareBlue Supplement – Preferred rate table in the Outline of Coverage for Plans D, F, High Deductible F and N, and to the MedicareBlue Supplement – Standard rate table in the Outline of Coverage for Plan A. You do **not** have to answer health questions and can proceed to Section F of the application.

If you do not qualify for guaranteed acceptance, please proceed to Section D.

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D. Answer the following health questions to determine what plans you are eligible for.

- Yes No **D1.** Do any of the following currently apply to you?
- Currently in the hospital, or have been within the last 90 days
 - Receive/require dialysis
 - Use bottled oxygen or an oxygen concentrator to help you breathe (not including a CPAP machine if you do not require oxygen)
- Yes No **D2.** In the last two years have you received medical advice, or testing in preparation for the following:
- Heart/bypass surgery (includes implanting of pacemaker or defibrillator but not updates to existing pacemaker)
 - Angioplasty/vascular surgery
 - Back or spine surgery
 - Joint replacement
 - Surgery for cancer
 - Surgery to remove a tumor of a major organ
 - Amputation due to disease
 - Organ transplant
- Yes No **D3.** In the last two years, have you received medical advice, treatment, or prescription medications from a health care professional for any of the following conditions:
- Liver problems: Cirrhosis or Hepatitis B or C
 - Internal organ or blood cancer
 - Stroke/Transient Ischemic Attack (TIA)
 - Amyotrophic Lateral Sclerosis (ALS)
 - Multiple Sclerosis (MS)
 - Acquired Immune Deficiency Syndrome (AIDS /or tested positive for HIV)
 - Kidney/Renal Disease: Chronic Renal Failure
 - Paraplegia/Quadriplegia

STOP

If you answered **YES to any** of the questions above, you are only eligible for Plan A. To determine your monthly premium amount, refer to the MedicareBlue Supplement – Standard rate table in the Outline of Coverage. Please proceed to Section F and select Plan A.

If you answered **NO to all** of the questions above, you are eligible for Plans A, D, F, High Deductible F and N. Please proceed to Section E to determine your rate.

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E. Answer the following health questions to determine if you qualify for preferred rating.

- Yes No **E1.** In the last two years, have you been diagnosed, treated, or been prescribed medication by a health care professional for any of the following conditions? If you answered yes, check all of the conditions that apply to you below.

Circulatory Conditions

- Aneurysm
- Artery Blockage
- Atrial Fibrillation or Flutter
- Cardiomyopathy
- Carotid Artery Disease
- Congestive Heart Failure
- Coronary Artery Disease
- Heart Attack
- Peripheral Artery Disease
- Ventricular Tachycardia
- Deep vein thrombosis/blood clot in vein
- Hemophilia

**Auto-immune Disorders/
Connective Tissue Disorders**

- Scleroderma
- Systemic Lupus Erythematosus (SLE)

Metabolic Conditions

- Diabetes (with complications such as: Neuropathy/nerve damage, Kidney disease, or Retinopathy) or require an insulin pump

Respiratory Conditions

- Chronic Obstructive Pulmonary Disease (COPD)
- Emphysema
- Chronic Bronchitis
- Chronic Asthma
- Chronic Interstitial Lung Disease
- Chronic Pulmonary Fibrosis
- Cystic Fibrosis
- Sarcoidosis
- Bronchiectasis

Cancer or Tumors

- Cancer (other than skin)
- Leukemia or Lymphoma
- Melanoma

Kidney Conditions

- Polycystic Kidney Disease
- Renal Artery Stenosis
- Chronic Renal Insufficiency

Gastrointestinal Conditions

- Chronic Pancreatitis
- Esophageal Varices

Musculoskeletal Conditions

- Amputation Due to Disease
- Rheumatoid Arthritis
- Spinal Stenosis
- Osteoporosis with fracture

Organ Transplant

- Organ Transplant
- Bone Marrow Transplant

Substance Abuse

- Alcohol Abuse or Alcoholism
- Drug Abuse or Use of Illegal drugs

Psychological /Mental Conditions

- Bipolar or Manic Depressive
- Major Depressive Disorder
- Schizophrenia
- Anorexia Nervosa

Eye Condition

- Retinopathy

**Neurological/Nervous System
Conditions**

- Hemiplegia – paralyzed on one side
- Alzheimer’s Disease/Dementia/
Cognitive disorders
- Parkinson’s Disease
- Myasthenia Gravis
- Seizure disorders

STOP

If you answered **YES** to question E1 above, you are eligible for Plans A, D, F, High Deductible F and N. To determine your monthly premium amount, refer to the MedicareBlue Supplement – Standard rate table in the Outline of Coverage.

If you answered **NO** to question E1 above, you are eligible for Plans D, F, High Deductible F and N. To determine your monthly premium amount, refer to the MedicareBlue Supplement – Preferred rate table in the Outline of Coverage.

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F. Choose the plan you are applying for.

Check the MedicareBlue Supplement Plan for which you are applying:

- Plan A
 Plan D
 Plan F
 High Deductible Plan F
 Plan N

G. Answer the following questions about your past and current coverage.

(Answer questions below by marking YES or NO with an "X".) To the best of your knowledge:

- Yes No
G1. (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.)
If yes,
 Yes No
(b) Will Medicaid pay your premiums for this Medicare supplement policy?
 Yes No
(c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?
- Yes No
G2. (a) Have 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)? If yes, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START _____ / _____ / _____ END _____ / _____ / _____
 Yes No
(b) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? If yes, please complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."
 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
G3. (a) Do you have another Medicare supplement policy in force?
(b) If so, with what company, and what plan do you have?

 Yes No
(c) If so, do you intend to replace your current Medicare supplement policy with this policy? If yes, please complete "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage."
(d) If so, what is the paid-to or expiration date of your policy: _____ / _____ / _____
- Yes No
G4. (a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan)
(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, leave "END" blank.
START _____ / _____ / _____ END _____ / _____ / _____

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H. Choose your method of payment.

Select how you would like to pay for your MedicareBlue Supplement premiums from one of the options below. Billing periods are based on a calendar year. Please do not send payment with this application. If the Bank Account Holder is not present to sign the application, you will need to complete and submit an Authorization for Automatic Account Withdrawal form (M-3506).

- H1. Direct Bill.**
 If so, on what basis? Quarterly Semi-annually Annually
- H2. Use billing information on file with Wellmark.** (Available only for those with current Wellmark individual coverage.)
- H3. Automatic Account Withdrawal from Applicant's account.**
- H4. Automatic Account Withdrawal from account other than Applicant's.**

If you selected payment method H3 or H4, please complete the following:

- On what basis? Monthly Quarterly Semi-annually Annually
 Date of withdrawal: 1st of the month 5th of the month
 From: Checking (*Attach voided check.*)
 Savings

Financial Institution Name: _____

Financial Institution Phone Number (optional): _____

Bank Account Name(s) (exactly as it appears on the account): _____

Financial Institution Routing Number (9 digits): _____

Account Number: _____

State Code (found on your check on the top right corner above the date--e.g., 78): _____

If paying by automatic withdrawal from checking include a voided check.

If Direct bill is *not* selected:

As the Bank Account Holder, I hereby authorize Wellmark to make automatic withdrawals from the account shown on the attached voided check in the amount of my periodic premium payment as it may be adjusted from time to time. If the undersigned is not the Applicant, I understand and agree that notices of any premium adjustments when provided to the Applicant shall constitute notice to the undersigned of any such adjustment. I hereby certify that I have read and understand the provisions of the Application Agreement and Certification section. This authorization shall supersede and replace any previous authorization given by me for automatic premium withdrawal.

Bank Account Holder's Signature (if other than Applicant) _____ Date ____/____/____

You may cancel automatic account withdrawal at any time. However, we need to receive your written notification at least 20 days before your scheduled withdrawal.

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Statements

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. 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 reinstated if requested within 90 days of losing your 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
5. 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 reinstated 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
6. 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).

Application Agreement and Certification

My signature on this application verifies that I have received the “MedicareBlue Supplement Outline of Coverage,” the “Guide to Health Insurance for People with Medicare,” and a completed copy of this application. My signature also verifies that I have read and understand the “Statements” section that appears above.

My signature verifies that, to the best of my knowledge and belief, I have answered the questions on this application truthfully and completely. I understand that my coverage will not begin until Wellmark Blue Cross and Blue Shield of South Dakota receives and accepts this application and applicable payment and assigns an effective date of coverage. If I answered “No” to the tobacco question on this application, I am eligible for a special tobacco non-user rate. If this status changes, I must notify Wellmark immediately. Wellmark may require me to recertify this status in the future.

My signature further verifies that I understand South Dakota law prohibits knowingly selling more than one Medicare supplement policy to an individual. I certify that if I currently have a Medicare supplement policy in force, I will cancel my current Medicare supplement policy upon notification of acceptance for coverage by Wellmark Blue Cross and Blue Shield of South Dakota. I can request that a Wellmark Blue Cross and Blue Shield of South Dakota representative review my existing policies and advise whether this MedicareBlue policy will duplicate the benefits of my existing health insurance policies by calling (877) 877-8411.

My signature also verifies that I authorize any health care provider to release medical records to Wellmark Blue Cross and Blue Shield of South Dakota when reasonably related to the health insurance coverage for which I have applied. If any law or regulation requires additional authorization for release of medical records,

Application Agreement and Certification, cont'd.

I will give this authorization.

I understand that premium payments may be made on a calendar month, calendar quarter, semi-annual calendar year or calendar year basis. For example, a monthly premium payment would be for the first day of a month through the last day of such month. A quarterly premium payment would be for any calendar quarterly period, such as January 1 through March 31. A semi-annual premium payment would be for the period of either January 1 through June 30 or July 1 through December 31. An annual premium payment would be for January 1 through December 31 of the applicable year.

In the event I choose to pay my premium on a quarterly, semi-annual, or annual basis and there is a mid-year increase in the amount of premium(s), I will have the following responsibility with regard to an increase in premium(s).

- **Quarterly Payments:** For quarterly premium payments, I must pay the remaining quarterly premium payments that include the premium increase.
- **Semi-annual Payments:** For semi-annual premium payments, I must pay a bill for a premium payment that equals the difference between the new semi-annual premium amount and the previously paid first semi-annual premium amount. I also will be required to pay a second semi-annual premium amount that includes the premium increase.
- **Annual Payments:** For annual premium payments, I must pay a bill for a premium payment that equals the difference between the new annual premium amount and the previously paid annual premium amount.

My signature additionally verifies that I understand and agree that the amount of my periodic premium

payment will change as provided in the policy being applied for and from time to time based on changes in my coverage, including but not limited to, changes in benefits, payment obligations (such as deductible, coinsurance and copayments), my age, changes in tobacco user status, or other factors that require adjustments to the total premium. These changes may occur at times other than an annual or other policy renewal.

I further understand and agree that, if I have elected to authorize automatic premium withdrawals from a deposit account, the automatic withdrawal will change periodically to correspond with the applicable premium. My authorization for automatic premium withdrawals shall include authorization for automatic withdrawal of any changed amount unless I call or provide my bank with written notice not less than three (3) business days before a scheduled withdrawal to stop the payment. If I call my bank to stop payment, I may be required to provide a written request within fourteen (14) days after my call. I will be responsible for any fee assessed by my bank for stop-payment orders that I make.

Acknowledgement

I have read and understand the "Statements" and "Application Agreement and Certification" sections on this application. If I am replacing my current coverage, I have completed the "Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage" page of this form. I hereby confirm the authority of Wellmark to make automatic withdrawals from my deposit account as set forth above under "Choose your method of payment," and that this authorization supersedes and replaces any previous authorization given by me with respect to such authority. I understand that any payment will be deposited immediately upon Wellmark's receipt of this application.

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Wellmark Blue Cross and Blue Shield of South Dakota
 PO Box 5023
 Sioux Falls, South Dakota 57117-5023

Applicant's Signature X _____ Date ____/____/____

OR

Power of Attorney (POA)/Legal Guardian (if applicable):
 If POA or Legal Guardian, include a copy of the appropriate legal documentation.

POA/Legal Guardian Name _____
(Please Print)

POA/Legal Guardian Signature X _____

POA/Legal Guardian Date ____/____/____

For Agent Only: List all policies you have sold to the applicant in the last five years, including those no longer in force.

Company	Policy Number	Type of Policy	In Force? (Y/N)

Agent Name _____
(Please Print)

Agent Signature _____ Date ____/____/____

Agent ID

Applicant Name (First, Middle, Last)

Social Security Number



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

Wellmark Blue Cross and Blue Shield of South Dakota
PO Box 5023
Sioux Falls, SD 57117-5023

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 insurance and replace it with a policy to be issued by Wellmark Blue Cross and Blue Shield of South Dakota Insurance Company. 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 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 ISSUER'S AGENT:

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 (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- 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) _____

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1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which 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. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

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)

(Typed Name and Address of Issuer, Agent, or Broker)

(Applicant's Signature)

_____/_____/_____
(Date)