Medicare Supplement Plan G Extra with $25 Welcome to Medicare Savings*

Congratulations!

Thank you for applying to Medicare Supplement Plan G Extra with $25 Welcome to Medicare Savings*.

Your enrollment application was received and will now be processed. It may take up to 10 days before you receive a confirmation letter in the mail.

If you entered your email address earlier, we'll email the confirmation to you.

Confirmation Number	M66027183530561G
Selected Plan	Medicare Supplement Plan G Extra with $25 Welcome to Medicare Savings*
Estimated Monthly Premium	$117.00
Application Date	08/18/2020
Member Name	KARL NESTER

Application for Blue Shield of California Medicare Supplement Plans

Here's how to apply

1. Please make sure you answer all questions completely and accurately. Provide ALL requested information.
2. Sign and date in all places indicated.
3. Fax to: (844) 266-1850

   Or Email to: Msinstall@blueshieldca.com

   Or Mail to:
   Blue Shield Supplement Installation
   P.O. Box 3008
   Lodi, CA 95241-1912

If you are a current member interested in transferring to a Medicare Supplement plan of equal or lesser value outside your enrollment period or to a richer benefit plan at any time, you must complete this application.

Plan F Extra will only be available to applicants who attained age 65 before January 1, 2020 or first became eligible for Medicare benefits due to disability before January 1, 2020.

Fields marked with an asterisk (*) are required

1.

Personal Information

Please enter your personal information in the spaces provided.

First Name*	KARL
Middle Initial	
Last Name*	NESTER
Home Address **(NO PO BOX)***	4451 SARATOGA AVE
Apt	
City*	SAN DIEGO
State*	CA
Zip*	92107
Home Telephone*	6193688524

Please enter your 10 digit phone number with no hyphen or spaces (e.g., 2125551212).

Email Address	knester1@gmail.com

2.

Mailing Address (If Different From Above)

Mailing Address	
Apt	
City	
State	Select
Zip	

3.

Billing Address (If Different From Above)

Billing Address

Apt

City

State Select

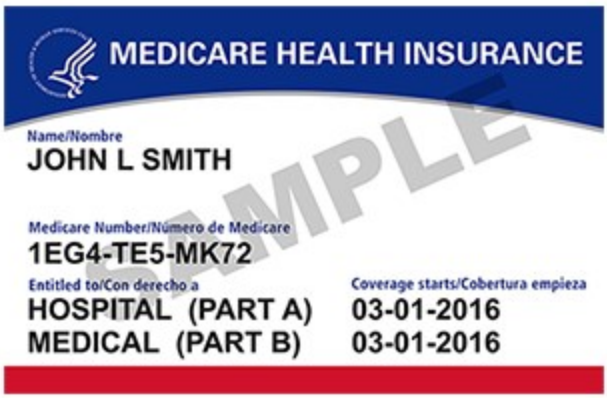
Zip

4.

Medicare Information

Please take out your red, white and blue Medicare card to complete this section. In the spaces provided, enter your Medicare Number (do not enter dashes) and the Effective Dates for your Part A and Part B coverage.

You must have Medicare Part A and Part B to join a Medicare Supplement plan.



Please indicate your Medicare Claim Number type:*

- (•) **Non Railroad Retirees**
- ( ) **Railroad Retirees**

Medicare Beneficiary Identification (MBI) number* 5WC5X49QC61

I am entitled to:

Hospital (Part A) Effective Date: *(MM/DD/YYYY)** 09/01/2020

Medical (Part B) Effective Date: *(MM/DD/YYYY)** 09/01/2020

Gender* ◉ **Male** ○ **Female** ○ **Non-binary**

Date of Birth* 09/25/1955

Requested Effective Date:

Month (1st day of) :* September

Year:* 2020

Language Preference* English

5.

Medicare Prescription Drug Plan Information

Are you currently a Blue Shield of California member?* ○ **Yes** ◉ **No**

6.

Guaranteed Acceptance

If you think you qualify for guaranteed acceptance, please select the number of the qualifying situation, as described in the Blue Shield Guaranteed Acceptance Guide, in the space below. Submit proof of prior coverage as a separate sheet, sign and date and fax the sheet to (844) 266-1850 or mail to: Blue Shield of California, P.O Box 3008, Lodi, Ca 95241-1912.

I believe I qualify for guaranteed acceptance based on situation number. 1

If applying for guaranteed acceptance under situation No 2 on the Blue Shield Guaranteed Acceptance Guide, please, complete the Notice of Replacement of Coverage form under question 4 on the next page.

7.

Household Savings Program

Each individual must complete their own application if not already an active member: If you and other member of your household are age 65 and older or older and both members have, or applying for the same plan (including any dental/vision plans), you may be eligible for a 7% monthly savings on your combined medical plan dues when both members are enrolled in the same eligible plan. Both members must share the same home and mailing addresses. Tobacco users are not eligible for the Household Savings Program.

☐

Is the other member of your household is enrolled in, or applying for, the same Blue Shield Medicare Supplement plan that you are applying for and share both addresses? please check this box:

If "Yes," Please provide the following information for the other household member:

If both members are either new enrollees or existing enrollees, the subscriber is determined based on which application is enrolled first. Otherwise the existing member already enrolled on the requested plan type will be designated as the subscriber.

The subscriber is responsible for payment of dues/premiums to Blue Shield and only the subscriber can make changes to the contract/policy. When enrolled under the Household Savings Program, Blue Shield will also accept payment of dues/premiums from the other household member enrolled on the plan. Billing information and amounts due can/will be shared with both parties enrolled on the plan when calling Customer Care.

8.

Payment Information

To determine the monthly dues amount, refer to Blue Shield's Medicare Supplement plans rate tables (link to PDF). If you are not approved, Blue Shield will refund your payment amount. If your application is approved, you will receive a bill indicating the amount and the date your next payment is due. Blue Shield will also send you an approval letter, an Evidence of Coverage and Health Service Agreement, and a member identification card as proof of approval.

Please choose one of the following options below for ongoing billing and payments*

○ **Quarterly Billing**

◉ **Monthly Billing**

Save $3 a month by paying dues through automatic monthly debit from your checking or savings account using our Easy$PaySM program1. To enroll, after receiving and paying for your first bill, register for and log into your Blue Shield account at blueshieldca.com and access the Payment Center tab. You may also call Customer Service at (800) 248-2341 TTY: 711 8 a.m - 5:30 p.m Monday through Friday. Requests to enroll in the Easy$Pay program may take up to two billing cycles for completion. Members should pay all paper bills received until a letter confirming registration in the Easy$Pay program is received.

Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.

9.

Current Insurance Coverage Information (Required For All Submissions)

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 contract, or that you had certain rights to buy such a contract, you may be eligible for guaranteed acceptance in one or more of our Medicare Supplements plans. The Blue Shield Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed issue of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed issuance may vary by situation, and you must apply within this time period to be eligible for guaranteed acceptance.

Please fax a copy of the front and back of your current carrier ID card. And please also include a copy of the notice from you prior insurer. Please fax the documents to (844) 266-1850 or mail to: Blue Shield of California, P.O Box 3008, Lodi, Ca 95241-1912.

Please answer all questions to the best of your knowledge. (Please check Yes or No below.)

1.

a. Did you turn 65 years of age 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?

*

09/01/2020

2.

a. Are you covered for medical assistance through California's Medi-Cal program?
NOTE TO APPLICANT: if you have a share cost under the Medi-Cal program, please answer No to this question.*

○ **Yes** ◉ **No**

3.

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 the "End "blank.*

○ **Yes** ◉ **No**

4a. Do you have any another Medicare Supplement plan policy or certificate or contract in force?*

○ **Yes** ◉ **No**

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**

5a. If so, what companies and what kind of policy?

Carrier Name:*	UNITED HEALTH CARE
Carrier Phone No:*	8885866365
Plan Type:*	HMO
Current ID No:*	9321876-02

5b. What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave the "End" blank.)

Start:*	01/01/2020
End:	

6. Are you under age 65?*

○ **Yes** ◉ **No**

You may contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at (800) 434-0222 for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California. A rate guide is available that compares the policies sold by different insurers. You can obtain a copy of this rate guide by calling the Department of Managed Health Care's consumer toll-free telephone number (1-888-466-2219), by calling the Health Insurance Counseling and Advocacy Program (HICAP) toll-free telephone number (1-800-434-0222), or by accessing the Department of Managed Health Care's Internet website (www.dmhc.ca.gov).

10.

Terms, Conditions, and Authorizations

Information regarding Medicare Supplement plan coverage: Before you apply, it's important that you read the following information, then sign and date at the end of this application.

1. You do not need more than one Medicare Supplement plan policy or contract.
2. If you purchase this contract, you may want to evaluate your existing health coverage to decide if you need multiple coverage.
3. You may be eligible for benefits under Medi-Cal or Medicaid, and may not need a Medicare

Supplement plan contract.
4. If after purchasing this contract you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement plan contract can be suspended, if requested, during your entitlement to benefits under Medi-Cal or Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal or Medicaid. If you are no longer entitled to Medi-Cal or Medicaid, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing Medi-Cal or Medicaid eligibility. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract 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 plan contract 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 plan contract can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement plan contract under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement plan contract (or if that is no longer available, a substantially equivalent contract) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement plan contract provided coverage for outpatient prescription drugs, and you enrolled in Medicare Part D while your contract was suspended, the reinstituted contract 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 are available in California to provide advice concerning your purchase of Medicare Supplement plan coverage and concerning medical assistance through the Medi-Cal program, including your benefits as a qualified Medicare beneficiary (QMB) and a specified low-income Medicare beneficiary (SLMB). You may obtain information regarding counseling services from the State Department of Aging.
7 Receiving materials and communications electronically versus print: You may receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website blueshieldca.com, as applicable. Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you. To receive printed materials in the mail, to opt out of email communications, please call (800) 248-2341 TTY: 711 8 a.m. – 5:30 P.m. Monday through Friday.

Conditions of Membership

1. I understand that this application and the Statement of Health, if applicable, together with the Evidence of Coverage and Health Service Agreement and any endorsements, appendices, and attachments thereto, will collectively constitute the entire agreement for coverage.
2. I will not receive coverage from Blue Shield unless Blue Shield's Underwriting Department approves this application. Blue Shield is not liable for bills incurred before the effective date of

approves this application. Blue Shield is not liable for bills incurred before the effective date of coverage.

3. Only Blue Shield can approve this application. I understand that any insurance agent, broker, or sales representative cannot grant approval, change terms, or waive requirements.

4. I acknowledge receipt of the Summary of Benefits, rate table, The Guide to Health Insurance for People with Medicare, and a copy of this application. With my signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Savings Program, and the authorizations I have provided. I have read the Summary of Benefits and the terms, conditions, and authorizations set forth above.

I certify that I meet the eligibility requirements set forth in the Summary of Benefits. I alone am responsible for the accuracy and completeness of this application and have answered all questions to the best of my knowledge and belief. I understand that I will not be eligible for coverage if any information is false or incomplete, and that coverage may be revoked based on such finding.

Applicant's Signature*	**Date***
KARL NESTER	08/18/2020

11.

Producer Information- Must Be Completed By Producer

Telephone Number	6193332580	☐ **Update**
Fax Number	6193332417	☐ **Update**
Producer First Name (writing agent)	Katia	☐ **Update**
Producer Last Name (writing agent)	M	☐ **Update**
National Producer Number*	16832437	
Email Address	kmontanez@shlinsurance	
Producer Address	1214 MARLINE AVE	
City	EL CAJON	
State	CA	
Zip	92021	

Is this online form an electronic copy of a paper application signed by the beneficiary? ○ **Yes** ◉ **No**

Please note: For auditing, Brokers please retain copy of the paper application.

12.

Section 1- Please list any other health insurance policies or plan contracts sold to the applicant as follows:

List policies and plan contracts sold that are still in force:	
List policies and plan contracts sold in the past five years that are no longer in force:	

13.

Section 2- If the applicant did not complete the Statement of Health section (is guaranteed acceptance), you do not need to complete this section.

A producer who assists an applicant or applicants in submitting an application to a health plan or insurer has a duty to assist the applicant (s) in providing answers to health questions accurately and completely.

This attestation must be completed by the producer and submitted with each Blue Shield Medicare Supplement plan application. This form is available for use with Medicare Supplement plan applications not containing a producer attestation with these questions and shall become part of the original application.

Review and select one of the following:

○ **I did not assist the applicant(s) in any way in completing or submitting this application. All information was completed by the applicant(s) with no assistance or advise of any kind from me.**

◉ **I assisted the applicant(s) in submitting this application. All information in the health questionnaire was provided by them. I advised the applicant(s) that they should answer all questions completely and truthfully and that no information requested on the application should be withheld. I explained that, if information is withheld, that could result in their coverage being cancelled later. The applicant(s) indicated to me that they understood these instructions and warnings. To the best of my knowledge, the information on the application is complete and accurate. I understand that, if any portion of this statement by me is false, I may be subject to civil penalties of up to $10,000.**

Super Producer Name	KATIA M MONTANEZ
Super Producer Number	0034245
Today's Date	08/18/2020
Producer's Signature*	KATIA M MONTANEZ
Print Name*	KATIA M MONTANEZ

Notice: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

1. Applicant's Statement of Health

Blue Shield does not collect or use genetic information in Underwriting. No genetic information, including family medical history, and no information related to HIV testing should be provided.

If you qualify for guaranteed acceptance, do not complete this section. (See the Guaranteed Acceptance section for qualifying information.) Otherwise, please check Yes or No to each of the following questions. If you answer Yes to any of the questions below, please provide additional information and dates associated with the condition as well as current status of the condition. If additional space is required, please use additional sheets as necessary, sign, date and fax to: (844) 266-1850 or mail to: Blue Shield of California, P.O. Box 3008, Lodi, CA 95241-1912.

1. Have you, within the past five years, received treatment or been hospitalized for any of the conditions listed below? If Yes, please explain the condition and indicate the date(s) of treatment after each question.

a. Brain or nervous system disdorders such as multiple sclerosis, Parkinson's disease, Huntington's chorea, dementia, Alzheimer's, paralysis, stroke, etc.

○ **Yes** ○ **No**

b. Respiratory system disorders such as chronic obstructive lung disease, emphysema, cystic fibrosis, etc.

○ **Yes** ○ **No**

c. Cardiovascular disorders such as heart disease, high blood pressure, angina, coronary artery disease, clotting disorders, etc.

○ **Yes** ○ **No**

d. Gastrointestinal disorders such as liver cirrhosis, Hepatitis, ulcerative colitis, etc.

○ **Yes** ○ **No**

e. Musculoskeletal system disorders such as rheumatoid arthritis, herniated or bulging discs, etc.

○ **Yes** ○ **No**

f. Metabolic disorders such as diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, etc., or immune system disorders such as lupus, Raynaud's, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT, HIVID, or pentamidine therapy.*

○ **Yes** ○ **No**

g. Cancer or malignant tumors.

○ **Yes** ○ **No**

h. Have you received treatment or been hospitalized for any other condition than those listed above?

○ **Yes** ○ **No**

2. Do you have a pacemaker or artificial heart valve, or have you had transplant surgery or heart surgery such as angioplasty or bypass? If Yes, please explain the condition and indicate the date of treatment.

○ **Yes** ○ **No**

3. Have you been bed-ridden or confined to a hospital, nursing home, convalescent hospital, or other institution within the past three years? If Yes, please explain the confinement and indicate the date of confinement.

○ **Yes** ○ **No**

4. Are you currently taking medication? If Yes, please list all medications you are currently taking, and the condition for which the medication is prescribed.

○ **Yes** ○ **No**

5. Have you used any tobacco-related products in the last 24 months?

○ **Yes** ◉ **No**

*California law prohibits an HIV test from being required or used by healthcare service plans as a condition of obtaining coverage.

I alone am responsible for the accuracy and completeness of the information provided in this application. I have personally reviewed all information provided on this application. To the best of my knowledge and belief, all information on this application, including all information provided in the Statement of Health Section, is accurate, true, and complete. I understand that coverage may be cancelled or rescinded if Blue Shield determines that information on this application is materially inaccurate, not true, or incomplete. I further understand that I must provide Blue Shield with any new information that arises after the submission of this application but before my enrollment with Blue Shield begins.

Signature	**Date**
KARL NESTER	08/18/2020

Authorization For Release of Medical Information

By signing below, you are authorizing the release of your healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent, to Blue Shield of California for the purpose of reviewing your application for Blue Shield coverage.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or valuating any claim for benefits.

You have the right to refuse to sign this authorization. However, Blue Shield has the right to condition your eligibility for coverage and enrollment determinations if you choose not to sign the authorization below unless you qualify for enrollment on the basis of guaranteed acceptance.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid until 1) for 30 months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health services agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

If you qualify for guaranteed acceptance, do not sign this release. (See the Guaranteed Acceptance section for qualifying information.)

Signature*	**Date***
KARL NESTER	08/18/2020

1. Dental PPO Plans

Dental plans and dental + vision package for Medicare Supplement plan members.
Please see the Blue Shield Dental Plans and dental + vision package for more information.

To sign up for Blue Shield dental coverage, select a plan below:

Please note that Plan F Extra and Plan G Extra include a vision benefit. If you are interested in dental coverage and are also enrolling in Plan F Extra or Plan G Extra, please select the Dental PPO 1000 or Dental PPO 1500 plan to avoid duplicative coverage.

Dental plan options (check one):*

- ○ **Specialty Duo dental + vision package**
- ○ **Dental PPO 1000**
- ○ **Dental PPO 1500**
- ◉ **No Dental plan**

You can save $3 each month for the first six months on your dental or dental + vision plan rates if you enroll in a dental or dental + vision plan at the same time you enroll in any Blue Shield Medicare Supplement plan.1

Conditions of coverage

Dental benefits aren't subject to health plan deductible requirements.
If your dental or dental + vision coverage is cancelled for any reason (by you or by Blue Shield), you may apply for reenrollment, but you will have to wait six months to reapply.

For Household Savings Program enrollment

You and your other household member need to select and both enroll in the **same** dental PPO plan or dental + vision package in order to receive one bill that combines Medicare Supplement plan and dental PPO plan or dental + vision package rates.

Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).
Specialty Duo Dental + Vision package includes both Specialty Duo Dental Plan and Specialty Duo Vision Plan for Medicare Supplement plan members.
Savings due to increased efficiencies from administering Medicare Supplement plans under this program/service are passed along to the subscriber.