



MASSACHUSETTS

Medex[®] Core, Medex[®] Sapphire, Medex[®] Bronze

APPLICATION FOR DIRECT BILLED MEDEX[®]

DIRECTIONS

- Please print clearly.
- Carefully read and answer all questions. Incomplete applications will not be accepted. Please keep a copy of the application for your records.
- Send us your application after you receive your red, white, and blue Medicare card.
- Don't send money with this application. You'll receive a bill when payment is due.
- **Please complete and return to:**
Blue Cross Blue Shield of Massachusetts
Enrollment Department
P.O. Box 55011
Boston, MA 02205
- Or, fax the application to **1-617-246-3633**.
- To enroll by phone, 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, call:
Medex Member Service:
1-800-258-2226 (TTY: 711)

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

- You're a resident of Massachusetts and you actually live in Massachusetts.
- You're eligible for Medicare Part A and Medicare Part B and enrolled in Medicare Part B.
- If you're under age 65, you qualify for Medicare coverage because of disability.

Notes: Medex Bronze shall, on or after January 1, 2020, only be offered to eligible persons who: (a) have attained 65 years of age before January 1, 2020; or (b) first became eligible for Medicare due to age or disability before January 1, 2020. Those who are otherwise eligible for Medicare Part A and B and who are enrolled in Medicare Part B, but who aren't eligible to purchase Medex Bronze, shall be eligible to purchase all other Direct Billed Medex plans that are currently offered.

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

Please answer all questions.

Check the Medex plan of your choice:

- Medex Core (Medicare Supplement Core)
- Medex Sapphire (Medicare Supplement 1A)
- Medex Bronze (Medicare Supplement 1)
- Medex Core with Vision and Hearing Benefit
- Medex Sapphire with Vision and Hearing Benefit
- Medex Bronze with Vision and Hearing Benefit

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
- Non-Binary

Your complete date of birth:

(____/____/____)
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Your telephone number:

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Your permanent home address:

Number and Street

City:

State:

ZIP Code:

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 Code:

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're 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 below section, then answer questions 1 through 5.

- You don't need more than one Medicare supplemental insurance policy.
- If you newly enroll in a Medicare Supplement 1 plan, you're not permitted to switch within the same company into a Medicare Supplement 1A plan until you have been covered by the company's Medicare Supplement 1 plan for at least 12 months.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for Medicaid benefits and may not need a Medicare supplemental insurance policy.
- The benefits and premiums under your Medicare supplemental insurance policy can be suspended, if requested, during your entitlement to benefit under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you're no longer entitled to Medicaid, your policy will be reinstated 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 reinstated policy won't have outpatient prescription drug coverage, as you'll be enrolled in the most comparable plan without outpatient prescription drug coverage.
- If you're 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 premium under your Medicare supplemental insurance policy can be suspended, if requested, while you're 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 reinstated 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 reinstated policy won't have outpatient prescription drug coverage, as you'll be enrolled in the most comparable plan without outpatient prescription drug coverage.
- Counseling services are available in Massachusetts to provide advice concerning your purchase of a 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.

To the best of your knowledge, [Mark Yes or No below with an "X"]

1. (a) Did you turn age 65 in the last six months?
 Yes No
(b) Did you enroll in Medicare Part B in the last six 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're participating in a "Spend-Down Program" and haven't 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

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're still covered under this plan, leave "End" blank. Start ___/___/___ End ___/___/___
- (b) If you're 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're still covered under the other policy, leave "End" blank.)

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:

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation, or gender identity.

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-678-2265** (TTY: **711**).

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para **1-800-678-2265** (TTY: **711**).

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