Horizon.

Application for Medicare Supplement Insurance for Individuals 65+

INSTRUCTIONS

Important Reminders	• You must be age 65 or older or turning age 65 in the next three months and have both Medicare Part A and Part B to apply for a Horizon Medicare Blue Supplement Plan. • Please print in blue or black ink. • We cannot process your application if you do not provide all required information.
Section 1 **CUSTOMER INFORMATION**	• If premium notices are to be mailed to an address other than the applicant's permanent residence address, please complete the mailing address.
Section 2 **MEDICARE INFORMATION**	• Copy your Medicare number and your Part A and Part B effective dates from your Medicare Card.
Section 3 **PAYMENT AND SCHEDULE**	• Do not send payment with the application. You will be billed later if your application is accepted. • Should you wish to pay your premium using Electronic Funds Transfer (EFT), please complete the EFT Discount form.
Section 4 **CHOOSE YOUR PLAN AND START DATE**	• Plan C and Plan F are not available if you turn 65 on or after 1/1/2020 and your Medicare Part A effective date is on or after 1/1/2020. • You may request a plan start date. In some situations, this date may not be available.
Section 5 **IS YOUR ACCEPTANCE GUARANTEED?**	• Your acceptance is guaranteed if you meet Medicare Supplement Open Enrollment Eligibility or Guaranteed Issue Eligibility: o Complete questions 5a-5b to determine if you meet the Medicare Supplement Open Enrollment Eligibility. o Complete question 5c to determine if you meet the Guaranteed Issue Eligibility. • Provide the following documentation if you are applying: o During the Medicare Supplement Open Enrollment Period: proof of prior creditable coverage. o Due to a Guaranteed Issue right: a copy of the termination notice from your prior plan or employer. Additional information may be requested.

Instructions continued on next page

Horizon.

Application for Medicare Supplement Insurance for Individuals 65+

INSTRUCTIONS (continued)

Section 6 **HEALTH STATEMENTS**	• If your acceptance is guaranteed based on Section 5, you do not need to complete the Health Statements. • All other persons must complete the Health Statements. Please answer yes or no to each question. If you leave a question blank, your enrollment may be denied.
Section 7 **PAST AND CURRENT HEALTH COVERAGE**	• If you are replacing your current Medicare Advantage plan, complete questions 7b through 7e and sign the Replacement Notice in Section 9. • You will not automatically be disenrolled from your Medicare Advantage plan when you submit this application. You must call your current insurance carrier to disenroll. o Submit a letter requesting termination of your Horizon Medicare Advantage plan with this application; or o Send a request to terminate your Horizon Medicare Advantage plan to: Horizon Healthcare of New Jersey P.O. Box 10138 Newark, New Jersey 07101 • If you are replacing your current Medicare Supplement plan, complete questions 7f and 7g and sign the Replacement Notice in Section 9.
Section 8 **AGREEMENT AND AUTHORIZATION**	• This section contains important information you must read. • Be sure to sign and date the application. • If you are authorizing a representative to sign the application on your behalf, additional information must be completed.
Section 9 **NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT OR MEDICARE ADVANTAGE COVERAGE**	• This section contains important information you must read if you are replacing your current Medicare Supplement or Medicare Advantage coverage. • Be sure to sign and date the Replacement Notice.

Horizon.

Application for Medicare Supplement Insurance for Individuals 65+

Policies are issued by Horizon Insurance Company, a subsidiary of Horizon Blue Cross Blue Shield of New Jersey.

Refer to the Instructions before completing this application and answer all questions to the best of your knowledge.

1 CUSTOMER INFORMATION

Last Name

First Name

MI

Date of Birth (MM DD YYYY)

Age

Sex (M F)

Permanent Residence Address (PO box not allowed)

City

State

Zip Code

Mailing Address (only if different from your permanent residence address)

City

State

Zip Code

Telephone Number (include area code) – –

Horizon Blue Cross Blue Shield of New Jersey ID # (if any)

Email Address (optional)*

*By providing your email address, you are agreeing to receive communications from Horizon BCBSNJ via email.

2 MEDICARE INFORMATION

Please fill in the blanks so they match your red, white and blue Medicare Card.

Medicare Number
(copy from your Medicare ID Card)

Hospital Insurance (Part A) Effective Date (MM DD YYYY)

Medical Insurance (Part B) Effective Date (MM DD YYYY)

Medicare Supplement plans are provided by Horizon Insurance Company. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies. Both are independent licensees of the Blue Cross Blue Shield Association.

3 PAYMENT AND SCHEDULE

Do not send payment with this application. You will be billed later.

3a. Please select how you would like to pay your bill.

☐ By Mail ☐ Electronic Funds Transfer (EFT) -If you select EFT, please fill out the EFT discount form.

3b. Please select how frequently you would like to be billed.

☐ Monthly ☐ Quarterly (every 3 months) ☐ Semi-Annually (every 6 months)

4 CHOOSE YOUR PLAN AND START DATE

4a. Plan Choice- Choose only one Horizon Medicare Blue Supplement plan.

☐ **Plan A** ☐ **Plan C**** ☐ **Plan D** ☐ **Plan F**** ☐ **Plan G** ☐ **Plan K** ☐ **Plan N**

**If you turn 65 on or after 1/1/2020 and your Medicare Part A effective date is on or after 1/1/2020, Plan C and Plan F are not available.

4b. Requested Plan Start Date: ☐☐☐☐☐☐☐☐

MM DD YYYY

Generally, your plan will start on the first day of the month following receipt and approval of this application.

5 IS YOUR ACCEPTANCE GUARANTEED?

Medicare Supplement Open Enrollment Eligibility

Your acceptance in any plan is guaranteed during your Medicare Supplement Open Enrollment Period, which lasts for six months beginning with the first day of the month in which you are both age 65 or older and enrolled in Medicare Part B. We will waive the pre-existing condition limitation if you had a continuous period of creditable coverage of at least six months and provide documentation of prior creditable coverage that shows an effective date and termination date, such as a letter from your prior insurer or a Certificate of Creditable Coverage.

5a. Did you turn 65 in the last six months or are you turning 65 in the next three months? ☐ Yes ☐ No

5b. Is your Medicare Part B effective date within the last six months or in the next three months? ☐ Yes ☐ No

If yes, what is the effective date? ☐☐☐☐☐☐☐☐

MM DD YYYY

If you answered **Yes** to question **5a** or **5b**, your acceptance is guaranteed and you qualify for the Preferred, non-tobacco user rate. Go directly to Section 7. Do not answer question **5c** or the questions in Section 6.

Guaranteed Issue Eligibility

5c. Did you lose or are losing other health insurance coverage as described below and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement policy, or that you have certain rights to buy such a policy? ☐ Yes ☐ No

In order to be eligible for these guaranteed issue rights without a pre-existing condition limitation, your application must be received no later than 63 days after the termination date of your health plan. You must also provide a copy of the termination notice you received from your prior plan or employer along with your application. The notice must verify the circumstances of your prior plan's termination and also describe your right to guaranteed issue of Medicare supplement insurance.

If one of these situations applies to you, you may be eligible for guaranteed issue rights. Not all plans are available as a guaranteed issue right.

You have Medicare and an employer group health plan (including retiree or COBRA coverage) or union coverage and: • The group health plan pays after Medicare pays and that plan is ending; or • The group health plan pays before Medicare pays and the plan terminates or you leave the plan.
You're in a Medicare Advantage Plan (like an HMO or PPO), a Program of All-inclusive Care for the Elderly (PACE) or a Medicare SELECT plan and: • Your plan is leaving Medicare or stops giving care in your area, or • You move out of the plan's service area; or • You leave the plan because the company has not followed rules, or misled you.
Your Medicare Supplement insurance company became bankrupt or insolvent and you lose your coverage, your Medicare Supplement plan otherwise ends through no fault of your own, or you left the Medicare Supplement plan because the company has not followed rules, or has misled you.
Horizon Medicare Blue Supplement Plans A, C, D, F, G and K are available to you

You dropped a Medicare Supplement policy to join a Medicare Advantage Plan (or to switch to a Medicare SELECT policy or a Program of All-inclusive Care for the Elderly (PACE)) for the first time, you've been in the plan less than a year, and you want to switch back.
Horizon Medicare Blue Supplement Plans A, C, D, F, G and K are available to you. Plan N is available if your prior plan was Horizon Medicare Blue Supplement Plan N.

You joined a Medicare Advantage Plan (like an HMO or PPO) or Program of All-inclusive Care for the Elderly (PACE) when you were first eligible for Medicare Part A at 65, and within the first year of joining, you decide you want to switch to Original Medicare.
Horizon Medicare Blue Supplement Plans A, C, D, F, G, K and N are available to you

- If you answered **Yes** to question **5c**, your acceptance is guaranteed and you qualify for the Preferred, non-tobacco user rate. You must include the termination notice from your prior insurer. Go directly to Section 7. Do not answer the questions in Section 6.
- If you answered **No** to question **5c**, continue to Section 6.

6 HEALTH STATEMENTS

You do not need to answer the questions in this section if your acceptance was guaranteed as defined in Section 5.

6a. Are you currently living in any type of nursing facility other than an assisted living facility? ☐ Yes ☐ No

6b. Have you been hospitalized within the past six months as an inpatient (not including overnight outpatient observation)? ☐ Yes ☐ No

6c. In the past 24 months, were you diagnosed, treated, given medical advice, prescribed medication, had surgery, or seen by a medical professional for any of the following conditions?

- Artery or vein blockage ☐ Yes ☐ No
- Peripheral Vascular or Arterial Disease (PVD/PAD) ☐ Yes ☐ No
- A heart attack, stroke, Transient Ischemic Attack (TIA) or mini-stroke ☐ Yes ☐ No
- Coronary Artery Disease (CAD), Cardiomyopathy (an enlarged heart) or Congestive Heart Failure (CHF) ☐ Yes ☐ No
- Chronic Obstructive Pulmonary Disease (COPD) or Emphysema ☐ Yes ☐ No
- Any lung or respiratory disorder requiring the use of a nebulizer or oxygen, or three or more medications for lung or respiratory disorder ☐ Yes ☐ No
- Diabetes, but only if you have circulation problems or retinopathy ☐ Yes ☐ No
- Cancer including Melanoma (but not other skin cancers), Leukemia, Multiple Myeloma or Lymphoma ☐ Yes ☐ No
- Cirrhosis of the liver, hepatitis or disorder of the pancreas ☐ Yes ☐ No
- Neuropathy or amputation caused by disease ☐ Yes ☐ No
- Myasthenia Gravis, Systemic Lupus or connective tissue disorder ☐ Yes ☐ No

6d. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?

- Parkinson's Disease, Lou Gehrig's Disease, Alzheimer's Disease, dementia, Multiple Sclerosis, Muscular Dystrophy or Cerebral Palsy ☐ Yes ☐ No
- Chronic kidney disease, kidney failure, kidney disease requiring dialysis, renal insufficiency or Addison's Disease ☐ Yes ☐ No
- Any condition requiring a bone marrow transplant or stem cell transplant or any condition requiring an organ transplant ☐ Yes ☐ No
- Acquired Immune Deficiency Syndrome (AIDS), AIDS-Related Complex (ARC) or tested positive for the Human Immunodeficiency Virus (HIV) ☐ Yes ☐ No

For questions 6a-6d:

- If any of your answers are **Yes**, your enrollment will be denied.
- If ALL of your answers are **No**, your enrollment will be accepted.

If your health status changes in the future, allowing you to answer "**No**" to all of the above questions, please submit a new application at that time.

6 HEALTH STATEMENTS (continued)

6e. Within the past 24 months, have you been medically diagnosed, treated, or had surgery for any of the following?

- Osteoporosis with fractures or Paget's disease ☐ Yes ☐ No
- Arthritis that restricts mobility or the activities of daily living ☐ Yes ☐ No

6f. At any time, have you been medically diagnosed, treated, or had surgery for any of the following?

- Congestive heart failure, un-operated aneurysm, defibrillator or pacemaker ☐ Yes ☐ No

For questions 6e-6f:

- If any of your answers are **Yes**, your rate will be the Standard Rate.
- If ALL of your answers are **No**, your rate will be the Preferred Rate.

6g. Within the past 12 months, have you smoked tobacco cigarettes or used any other tobacco product? ☐ Yes ☐ No

For question 6g:

- If you answer **Yes**, your rate will be the tobacco user rate.
- If you answer **No**, your rate will be the non-tobacco user rate.

7 PAST AND CURRENT HEALTH COVERAGE

Unless noted differently, the following questions should be answered yes or no to the best of your knowledge.

Medicaid Coverage Information

7a. Are you covered for medical assistance through the State Medicaid program? ☐ Yes ☐ No
Note: 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, will Medicaid pay your premiums for this Medicare supplement policy? ☐ Yes ☐ No

And, do you receive any benefits from Medicaid other than payments toward your Medicare Part B premium? ☐ Yes ☐ No

Medicare Advantage Coverage

7b. If you have 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 to the right. If you are still covered under this plan, please provide your desired end date.

Start Date: ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)

End Date: ☐☐ ☐☐ ☐☐☐☐ (MM DD YYYY)

7c. 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

If Yes, please complete Section 9 Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage Coverage.

7d. Was this your first time in this type of Medicare plan? ☐ Yes ☐ No

7e. Did you drop a Medicare supplement policy to enroll in the Medicare plan? ☐ Yes ☐ No

Medicare Supplement Coverage

7f. Do you have another Medicare supplement policy in force? ☐ Yes ☐ No

If Yes, with what company? Company Name:

And, what Plan? Plan:

7g. Do you intend to replace your current Medicare supplement policy with this policy? ☐ Yes ☐ No

If Yes, please complete Section 9 Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage Coverage.

Group or Individual Insurance Coverage

7h. Have you had coverage under any other health insurance plan within the last 63 days? (For example, an employer, union or individual plan) ☐ Yes ☐ No

If Yes, with what company? Company Name:

And, what kind of policy? Policy Type:

7i. What are your dates of coverage under the other policy? If you are still covered under the other policy provide your desired end date.

Start Date: MM DD YYYY

End Date: MM DD YYYY

8 AGREEMENT AND AUTHORIZATION MUST BE COMPLETED

Review the below statements before you sign the application.

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- 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 reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you were enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- 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 reinstituted if requested within 90 days of losing your employer or union-based health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you were enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services are available in New Jersey to provide advice concerning your purchase of Medicare supplement coverage 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).

8 AGREEMENT AND AUTHORIZATION MUST BE COMPLETED (continued)

I understand that: (a) my Medicare Supplement policy will not be effective before the date I am enrolled under both Parts A and B of the Medicare Program; (b) if I omit or falsify any statement in this application, the Plan can cancel this policy; (c) my policy, if issued, will cover only me; and (d) my policy does not cover any pre-existing conditions until six (6) months after the effective date of coverage. I certify that I am a permanent resident in New Jersey. Also, I agree that any physician, hospital, or other provider is authorized to give the Plan required information about my medical history. I acknowledge receipt of *A Guide to Health Insurance for People with Medicare* (located at HorizonBlue.com/medigapguide). **Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.**

Signature _____ Date _____

If you are replacing your Medicare Supplement Insurance or Medicare Advantage Coverage, complete the replacement notice on the next page.

If you are the authorized representative, you must sign above and provide the following information:

First Name _____ Last Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number _____ – _____ – _____

Relationship to Enrollee _____

If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request.

AGENT USE ONLY:

GA ID: _____ GA Receipt Date: _____ (MM DD YYYY)

NPN# _____ (Selling Agent) Phone #: _____

Name of Broker: _____

Receipt Date: _____ (MM DD YYYY) Effective Date: _____ (MM DD YYYY)

Location ID: _____

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

Save this notice! It may be important to you in the future

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage coverage and replace it with a policy to be issued by Horizon Insurance Company. Your new policy provides 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 the 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 Horizon Insurance Company

I have reviewed your current medical 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 premium
- ☐ Fewer benefits and lower premiums
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment:

- ☐ Other (please specify):

1. Health conditions that you may presently have (pre-existing 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 may have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing 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 _____ Date _____

Applicant Signature _____ Date _____