Enrollment Instructions

Empire BlueCross
An Anthem Company

4 ways you can enroll

Fill out your application online at **empireblue.com** (fastest).

Give us a call at **888-849-2420**.

Work directly with your insurance agent.

Fill out the paper application and fax or mail it.

Application checklist

- ☐ Find the plan you want.
- ☐ Fill out all sections that apply to you.
- ☐ Choose how to pay your monthly premium. If you choose Automatic Bank Draft, please send the Premium Payment Form.
- ☐ Sign and date the application and submit it. (It's a good idea to keep a copy for your own records.)

If you're faxing or mailing the application, please include any additional forms.

Fax (preferred)
844-236-7967

Mail
Empire BlueCross
P.O. Box 659816
San Antonio, TX 78265-9116

We're here to help if you have questions
888-849-2420

PLEASE NOTE

- You must live in New York for this plan.
- You will want to submit your application within 90 days of the signature date. Your requested effective date must be within 180 days of application signature.

Services provided by Empire HealthChoice Assurance, Inc., licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

An Anthem Company

Application for Medicare Supplement – New York

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116

Do you currently have an Empire Medicare Supplement Plan? .... ☐ Yes ☐ No

SECTION 1

1A. Applicant information (Use black ink and print your name as it appears on your Medicare ID card.)

Last name	First name	MI	Sex ☐ M ☐ F
Home street address (physical address, not a P.O. Box)			Apt #
City	County	State	Zip code
Mailing address (if different than above)	City	State	Zip code
Billing address (if different than above)	City	State	Zip code
Date of birth (MM/DD/YYYY)	Phone number		
Email address			

Language Preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Other ____________

1B. Eligibility and plan choice

Requested policy effective date: ______ / ______ / ________
MM DD YYYY

Coverage is effective as of the 1st of the month following approval of your completed application unless continuation of coverage requires you to request a date other than the 1st of the month.

Please complete the information below using your Medicare ID card (include all letters and numbers).

Medicare number: ________________________________

Hospital (Part A) effective date: ______ / 01 / ________
MM DD YYYY

Medical (Part B) effective date: ______ / 01 / ________
MM DD YYYY

Select from the following:

☐ Plan A ☐ Plan B ☐ Plan F* ☐ Plan G ☐ Plan N

1B. Eligibility and plan choice *(continued)*

➔ If replacing a Medicare Supplement or Medicare Advantage plan, please be sure to complete and return the **Notice of Replacement of Coverage** form and submit with your application.

*Plan F is available to those who first became eligible for Medicare before January 1, 2020.

SECTION 2

2A. How do you wish to pay your premium? (SEND NO MONEY NOW!)

Automated bank draft

☐ I would like my payment to be deducted automatically.

➔ My **Premium Payment Form** will be attached to this application.

Paper bill (Using billing address in **Section 1A**)

☐ Quarterly

☐ Annual – save $48 per year

2B. Other coverage information

Important Statements

Please read the statements below, then answer all questions to the best of your knowledge.

1. **You do not need more than one Medicare Supplement policy.**

2. If you purchase this policy (certificate), 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 (certificate).

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 reinstituted if requested within 90 days of losing 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 reinstituted 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 reinstituted 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 reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

2B. Other coverage information *(continued)*

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).

RESPONSES TO THE FOLLOWING QUESTIONS ARE REQUIRED FOR YOUR PROTECTION.
To the best of your knowledge, please answer all questions by marking "Yes" or "No" with an "X".
If you recently lost, are losing or replacing other health insurance coverage and received a notice stating you were eligible for guaranteed issue of a Medicare Supplement 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 Supplement plans. **Please include a copy of the notice with your application.**

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**

If yes, what is the effective date? ____________________

2. Are you covered for medical assistance through the state Medicaid program? ☐ **Yes** ☐ **No**
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,

A. Will Medicaid pay your premiums for this Medicare Supplement 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, like a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. (If you know your upcoming coverage end date, then enter that date).

START _____ / _____ / ______ END _____ / _____ / ______

B. If ending, indicate reason why your coverage is ending: ________________________________

C. 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**

D. Was this your first time in this type of Medicare plan? ☐ **Yes** ☐ **No**

E. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ☐ **Yes** ☐ **No**

4. A. Do you currently have a Medicare Supplement policy in force? ☐ **Yes** ☐ **No**

B. If yes, Company: ____________________________ Plan: ________________________________

Do you intend to replace your current Medicare Supplement policy with this policy? ☐ **Yes** ☐ **No**

If yes, what is your "START" and expected "END" Date?

START _____ / _____ / ______ END _____ / _____ / ______

C. Has your coverage under the previous plan been involuntarily terminated for reasons other than nonpayment of premiums or for fraud? ☐ **Yes** ☐ **No**

2B. Other coverage information *(continued)*

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 yes, Company: ____________________________ Policy type: ______________________________________

B. If yes, what are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank. If you know your coverage end date, then enter that date.)

START _____ / _____ / ______ END _____ / _____ / ______

2C. Authorizations and agreements

I, the applicant or my authorized representative:

1. affirm all answers provided on this application are true, complete and correct **(including information relating to Medicare coverage) and that Coverage may only be rescinded for material misrepresentation (or non-payment of premium)** and that it is my/our responsibility for accurately completing this application;

2. understand that coverage may be rescinded for failure to pay premium or material misrepresentation. Empire BlueCross will reimburse any premium paid less any claims paid and I/we will be responsible for claims paid exceeding any premium paid;

3. understand that I/we are responsible for notifying Empire BlueCross in writing of any new/changes to information on this application before coverage becomes effective that makes my application incorrect or incomplete;

4. understand there is a six-month benefit waiting period for any condition that I received medical treatment or advice in the six months prior to the effective date of this Medicare Supplement policy. Prior health insurance coverage will be counted toward this 6-month benefit waiting period, if there is not a break in health insurance coverage greater than 63 days;

5. understand the selling agent (if applicable) has no authority to promise coverage or to modify the Company's underwriting policy, premium or terms of any Company coverage and that he/she may be compensated based on my enrollment;

6. understand upon acceptance that my application will become part of the agreement between the Company and myself;

7. authorize Empire BlueCross to use and disclose my personal information when necessary for the operation of my health or other related activities and that Empire BlueCross will comply with the HIPAA Privacy Rules and any disclosures will be done in accordance with applicable laws;

8. understand that my payment by check (or resubmission due to insufficient funds) may be converted to an electronic Automated Clearinghouse (ACH) debit transaction, that my check will not be returned to me and that this process will not enroll me in any automatic debit process;

9. acknowledge responsibility for any overdraft fees permitted by state law;

10. acknowledge receipt of:
- Choosing a Medigap Policy: *A Guide to Health Insurance for People with Medicare,*
- the *Outline of Coverage,* and a copy of this application

2D. **Policy issuance** Email is the fastest, easiest way to get important plan information.

I agree to receive electronically the following materials based on my email address provided in Section 1A:

- ✔ **General information about my benefits, health programs and other services offered by Empire that are available to me**
- ✔ **Important Plan documents:**
  - **Medicare's annual Notice of Change (includes upcoming changes to Medicare amounts)**
  - **Welcome Kit (including my Plan Policy)**
  - **Renewal Notices (including upcoming premium changes)**
  - ☐ No thanks, I prefer to get my important plan documents by paper mail.
- ✔ **Medicare Supplement Explanation of Benefits (EOBs) (claims information)**
  - ☐ No thanks, I prefer to get my EOBs by paper mail.

I understand I can change my email preference at any time by logging into my secure member profile at www.empireblue.com or calling the customer service number on the back of my Medicare Supplement plan ID card.

IMPORTANT: This application cannot be processed until the applicant signs below. By signing below, the applicant certifies that he/she understands and agrees to the Authorizations and Agreements outlined in this application.

Please do not cancel your present coverage, if any, until you receive documentation from Empire BlueCross, such as an ID card or written notification, showing that your application has been approved.

SEND NO MONEY NOW — PAYMENT IS NOT DUE UNTIL YOUR APPLICATION IS APPROVED.

Signature of applicant, or authorized representative (if applicable)*	Date

*If signed by an authorized representative, a copy of the authority to represent applicant must be attached to application (such as a Power of Attorney).

SECTION 3: AGENT/BROKER ONLY

3A. Agent/broker information

Before this form can be processed the agent/broker must be appointed with us.

Agent/broker's printed name: ______________________

Agent/broker #: ______________________

Agency #: ______________________

Agency name: ______________________

(Any commission will be processed using these identification numbers.)

Street address: ______________________

City: __________ State: ____ ZIP code: __________

Phone: (________) ______________________

Fax: (________) ______________________

Email: ______________________

3A. Agent/broker information *(continued)*

Attestation – please check one of the following:

☐ I did not assist this applicant in completing and/or submitting this application by phone, e-mail or in person.

☐ I certify that the applicant has read, or I have read to the applicant, the completed application. To the best of my knowledge, the information on this application is complete and accurate. I explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and the applicant understood the explanation. I certify that the applicant realizes that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

Agent: If you state any material fact that you know to be false, you are subject to a civil penalty.

List all health insurance policies sold to the applicant in the past five (5) years, either in force or not:

Company name	Policy/ certificate number	Type of coverage	Policy effective date	Policy term date (if applicable)

I have requested and received documentation that indicates that the policy applied for will not duplicate any health insurance coverage. I have verified the information in the Replacement Notice section.

Signature of agent/broker | Date

If you are a current Empire BlueCross member and enrolling in a Medicare Supplement policy and have dependents that need to retain current coverage, please call the Customer Service number on the back of your ID Card. If you purchased your Empire policy through the ACA Marketplace, you will need to call the ACA Marketplace to cancel your policy and to retain coverage for your dependents.

Services provided by Empire HealthChoice Assurance, Inc., licensee of the Blue Cross Blue Shield Association, an association of independent Blue Cross and Blue Shield plans.

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Empire BlueCross

P.O. Box 659816 • San Antonio, TX 78265-9116

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Empire BlueCross. 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, agent, broker or other representative:

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 Medicare Part D.
☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

____

☐ Other. (please specify) ____

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which 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 might 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)*
Typed name and address of issuer, agent or broker

____ ______________________
(Applicant's signature) (Date)

*Signature not required for direct response sales

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Medicare Supplement Insurance or Medicare Advantage

Empire BlueCross

P.O. Box 659816 • San Antonio, TX 78265-9116

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

According to information you have furnished, you intend to terminate your existing Medicare Supplement insurance or Medicare Advantage and replace it with a policy to be issued by Empire BlueCross. 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, agent, broker or other representative:

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 Medicare Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

  ____
- ☐ Other. (please specify) ____

1. **Note:** If the issuer of the Medicare Supplement policy being applied for does not, or is otherwise prohibited from imposing pre-existing condition limitations, please skip to Statement 2 below. Health conditions which 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 might 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)*
Typed name and address of issuer, agent or broker

____ ______________________________

(Applicant's signature) (Date)

*Signature not required for direct response sales

Premium Payment Form for Medicare Supplement

Empire HealthChoice Assurance, Inc.
P.O. Box 659816 • San Antonio, TX 78265-9116 • Fax: 1-844-236-7967

Simplify Your Life! It saves you valuable time and money.
When enrolling in a Medicare Supplement plan, sign up for monthly Automatic Bank Draft (ABD) and save $2 per month. Drafts are made to your account on the 5th day of the month.

To ensure proper payment setup, this form MUST be returned with your Application.
Please print and use black ink.

Please print your name as it appears on your Medicare card.	Medicare Number:

I understand that the premium I have selected to pay through ABD is for my:

☐ Medicare Supplement plan

Premiums are subject to change on or after the policy renewal date in accordance with the terms of the Policy. Your premium billing preference selection does not guarantee your premium for any specific time period.

Banking Information for ABD Withdrawals
(See next page for help locating bank routing and account numbers. To ensure proper set-up, please include the routing number from a check and not a deposit slip.)

Deduct premium: Start date: ________ / _______ / ___________

☐ **Monthly** ☐ **Quarterly** ☐ **Annual**

Deduct premium from:
Checking: ☐ Personal ☐ Business **– OR –** **Savings:** ☐ Personal ☐ Business

Account holder name(s)	Name of financial institution
Bank Routing/Transit Number (9 digits)	Bank Account Number
☐☐☐☐☐☐☐☐☐	

Automatic Bank Draft Payment: I hereby authorize the Company to make withdrawals from the account indicated above for the then-current premium(s), and the designated financial institution named above to debit the same account.

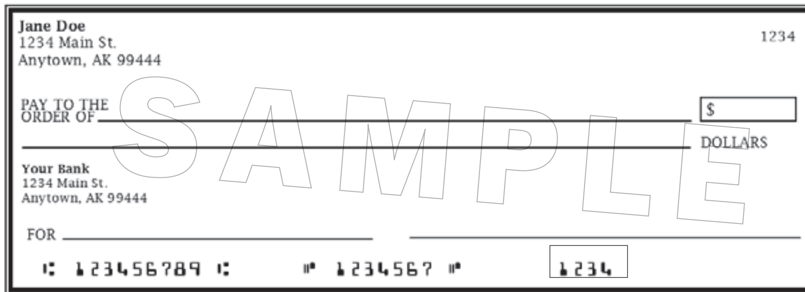
I understand that I am responsible to pay my premiums on schedule until set up on Automatic Bank Draft. If any premiums are owed to Empire when set up, I authorize my bank to draft both the past due premium along with current premium(s) to ensure my coverage stays in effect. I understand if changes I make to my plan impact my auto withdrawal amount and the change occurs close to the auto withdrawal date, Empire may not be able to notify me of the new auto withdrawal amount before the withdrawal is made. If I close this account, it is my responsibility to provide notification at least two weeks in advance of closing the account. I acknowledge responsibility for any overdraft fees permitted by state law.

I understand that this authorization is in effect until I either submit written notification or by phone, allowing reasonable time to act upon my notification. (**Exception:** In the event payment is returned due to insufficient funds, you will be converted to paper billing.) I also understand that if corrections in the debit amount are necessary, it may involve an adjustment (credit or debit) to my account. I understand Empire and my financial institution have the right to discontinue the bank draft if they wish to do so. I understand my monthly bank statement will reflect the premium transaction and that I will not receive a bill.

Return this authorization as indicated above. **No service fees apply when paying by ABD.**

Account holder's signature (as it appears on your bank account) **X**	Date

To find the Bank Routing and Account Numbers:



123456789

Routing Number

(9-digits: Be sure to use the routing number from an actual check. ***Do not use*** *the routing number from a bank deposit slip.)*

1234567

Account Number

(Sometimes the check number and Account Number are reversed.)

1234

Check number

(Do not include the check number as part of the Routing or Account Number.)

Services provided by Empire HealthChoice Assurance, Inc., licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield plans. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Empire BlueCross

An Anthem Company

AUTHORIZATION FOR THIRD PARTY DESIGNATION TO RECEIVE NONPAYMENT OF PREMIUM NOTICES

Under New York law, you may choose someone (called a third party designee) to get notices if we do not receive your Medicare Supplement insurance premium. In the event your premium is not received by its due date, a THIRD PARTY BILLING STATEMENT will be sent to this designated person. If your coverage is terminated for nonpayment, we will also send a THIRD PARTY TERMINATION letter to this designee. This is optional and can be done at the time of application or at a later date. Both you and the person you choose must sign this form.

Please note, for designation and other purposes, it is Empire's policy to accept direct premium payments made on behalf of an applicant or member **ONLY** from the following:

- Family member related by blood, marriage or adoption;
- Legal guardian and/or conservator;
- Powers of attorney;
- Trustee acting on behalf of an applicant or member who is a beneficiary of the trust; or
- Any other organization or individual from whom we are legally required to accept direct premium payments on an applicant or member's behalf.

To clarify, we do not accept direct premium payments from third party organizations or individuals who do not meet the above criteria.

THIRD PARTY DESIGNEE INFORMATION:

Last name | **First name** | **Middle initial**

Mailing address | **Apartment number**

City | **State** | **ZIP code**

Telephone number

I understand that, as third party designee, I must notify both the member and Empire HealthChoice Assurance, Inc. in writing if I decide to terminate the Designation and affirm that I meet the above guidelines as to whom may serve as a designated third party.

Designated third party signature ______________________ Date ____________

(Continued on back)

Applicant, member information:

Member name: ____

Empire Medicare Supplement member identification number: ______________________ (required)

Date of birth: ___________________________

I authorize Empire HealthChoice Assurance, Inc. to send, to the third party designee, a THIRD PARTY BILLING STATEMENT and a THIRD PARTY TERMINATION letter for the member named above.

This Authorization is valid for the duration of my coverage with Empire unless a different expiration date is indicated here: ___________________________ (specify month, day, year).

I understand that this Designation does not include the ability to make decisions concerning my health care. I also understand that I may revoke this Designation at any time, except to the extent that action has been taken in reliance upon it, by submitting a request in writing to Empire. I understand that the person/entity I have named to receive information may not be subject to privacy laws. They may be able to release the information, and privacy laws may no longer protect the information.

I do hereby affirm that I am the member or the person with the legal authority (appropriate legal documentation must be provided) to act on behalf of the applicant, member and affirm my designated third party meets the above guidelines as to whom may serve as a designee.

____ ______________________

Applicant, member/legally authorized person signature Date

____

Authority of person signing form (e.g., power of attorney)

Mail to:

Empire HealthChoice Assurance, Inc.
P.O. Box 659816
San Antonio, TX 78265-9116