

Personal Information

Name (First/Middle Initial/Last)			
Are you an Arizona resident? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Physical (Home) Address			
Home City	Home State	ZIP	
Mailing Address (if different from above)			
Mailing City	Mailing State	ZIP	
Billing Address (if different from above)			
Billing City	Billing State	ZIP	
Telephone Number	Email address*		
Date of Birth (MM/DD/YYYY) / /	Gender <input type="checkbox"/> M <input type="checkbox"/> F	Medicare Number	AZ Blue Member ID Number
*By providing an email address in this application, I agree to receive communications electronically from AZ Blue at that email address.			

Your Choice of Coverage:

Senior Security SM	Senior Preferred SM (Medicare Select)	Senior Security	Senior Preferred (Medicare Select)
Available throughout Arizona Plan: <input type="checkbox"/> A <input type="checkbox"/> D <input checked="" type="checkbox"/> G <input type="checkbox"/> N	Available in Maricopa, Pima, Apache, Cochise, Coconino, Mohave, Pinal, and Santa Cruz counties Plan: <input type="checkbox"/> D <input type="checkbox"/> G <input type="checkbox"/> N	Plan: <input type="checkbox"/> C ⁺ <input type="checkbox"/> F ⁺	Plan: <input type="checkbox"/> C ⁺

Your Desired Effective Date

1st day of (month)					
<input type="checkbox"/> Jan	<input type="checkbox"/> Mar	<input type="checkbox"/> May	<input type="checkbox"/> July	<input type="checkbox"/> Sept	<input type="checkbox"/> Nov
<input type="checkbox"/> Feb	<input type="checkbox"/> April	<input type="checkbox"/> June	<input type="checkbox"/> Aug	<input type="checkbox"/> Oct	<input type="checkbox"/> Dec

*Starting January 1, 2020, Medicare Supplement plans will no longer cover the Part B deductible for people who are new to Medicare. Because of this change, Medicare Supplement Plans C and F will be available only to people who are eligible for Medicare before January 1, 2020.

ACKNOWLEDGEMENT AND ATTESTATION for Medicare Supplement Household Discount



An Independent Licensee of the Blue Cross Blue Shield Association

MEMBER 1	First Name	Last Name		Middle Initial
	Member ID Number <i>(leave blank if Member ID Number has not been issued)</i>			
	Physical Street Address	City	State	ZIP
MEMBER 2	First Name	Last Name		Middle Initial
	Member ID Number <i>(leave blank if Member ID Number has not been issued)</i>			
	<input type="checkbox"/> Check here if Member 2's physical street address is the same as Member 1 listed above			

Acknowledgement and Attestation:

Blue Cross® Blue Shield® of Arizona (AZ Blue) offers a household discount to effective AZ Blue Medicare Supplement policy holders residing at the same residential address. Only Medicare Supplement policies qualify. The percentage of the household discount will vary depending on when the policy was written. Grandfathered Medicare Supplement policies written prior to 2018 will receive a 5% household discount and Non-Grandfathered policies written 2018 and after will receive a 7% household discount. Commercial, Individual, Group, standalone Part D prescription drug, and Medicare Advantage policies do not qualify for the household discount. Assisted living facilities, group homes, and other non-residential settings do not qualify for the discount. AZ Blue may request additional documentation from any person applying for or receiving the discount.

I attest to the best of my knowledge that the individuals listed above are each enrolled in a Medicare Supplement policy issued by AZ Blue and meet all other eligibility requirements for the AZ Blue Medicare Supplement household discount. I understand and acknowledge that AZ Blue may periodically audit for continued discount eligibility, and I agree to provide any additional documentation requested by AZ Blue within the requested timeframe to verify eligibility.

AZ Blue reserves the right, upon thirty (30) days' notice to the members listed above, to terminate the household discount for any of the following reasons: (1) the household discount program has been discontinued; (2) the members, for any reason, voluntarily or involuntarily, no longer live at the same address; (3) the members, for any reason, voluntarily or involuntarily, are no longer current members of an AZ Blue Medicare Supplement plan.

If an active Medicare Supplement policy holder becomes deceased while enrolled in the household discount program, the household discount will continue to be applied to the surviving policy holder's premium through the policy end date, in accordance with payment terms and policy eligibility.

Termination of the household discount program does not terminate a member's individual policy with AZ Blue.

Applicant/Member 1 Signature

_____/_____/_____
Date

Applicant/Member 2 Signature

_____/_____/_____
Date

Mail this form to:
Blue Cross Blue Shield of Arizona **Attn:** Enrollment
P.O. Box 13466
Phoenix, AZ 85002-3466

Payment Information

Please select your monthly method of payment:

- Continue with current payment method
 Autopay Electronic Bank Draft – Please complete the Autopay Authorization included with this form
 Paper bill

Save the trouble of writing us a check. With autopay, there's no paper bill to keep track of, no check to write, and nothing to mail. Instead, your premium is automatically withdrawn from your checking or savings account.

If the deduction for your first month's premium is delayed, the initial amount withdrawn may be more than one monthly premium.

Electronic Billing Information

Pay your premiums the convenient way with autopay.

Please debit my: Checking Savings

ROUTING TRANSIT NUMBER _____

ACCOUNT NUMBER _____

JOHN DOE 123 Any Lane Anytown, USA 12345		Date _____	123
Pay to the ORDER OF _____		\$ _____	
MEMO _____			
⑆0101010101⑆	⑆0101010101⑆	123	
<small>Routing Number</small>	<small>Account Number</small>	<small>Check Number</small>	

For the Financial Institution

- I authorize AZ Blue to start an automatic periodic charge to my checking or savings account as noted above. I also authorize my financial institution to reduce my account balance each period by the amount of that charge, just as if I wrote a check or withdrawal slip. Each withdrawal will appear on my account statement.
- I want this charge to continue automatically until I write AZ Blue telling them to discontinue my autopay service.
 - I agree to allow a reasonable time for discontinuation of autopay withdrawals, and I understand AZ Blue will refund premium that may be due to me based on the time necessary to terminate autopay withdrawals.
- I understand AZ Blue and my financial institution have the right to discontinue this service if either elects to do so.
- I further agree that if there are insufficient funds at the time my account is debited, the amount may be debited again that month, or for twice the amount the following month. My AZ Blue coverage will be terminated if there are insufficient funds in two consecutive drafts.
- I have read and agree to abide by the autopay conditions as outlined on this authorization form. I understand any applicable refund of monies due will be released 30 days after the last draft date.

Member Name (please print) _____

Authorized Signature on Account _____ Date ____ / ____ / ____
 (M M / D D / Y Y Y Y)

AZ Blue accepts insurance premium payments made by the insured, Power of Attorney, a relative or legal guardian on behalf of the insured. AZ Blue reserves the right to decline insurance premium payments from third parties other than a relative or legal guardian of the insured.

Acknowledgments—read this section and sign at the end

- I.** I have carefully read all of this form and the information I provided. I understand and agree that it will be part of my contract with Blue Cross Blue Shield of Arizona (AZ Blue).
- II.** I understand and agree that:
- the information I've provided is material to AZ Blue's decision to offer healthcare coverage.
 - AZ Blue will rely on the accuracy of the information to determine my eligibility for coverage and the premium rate I will pay for that coverage.
 - if AZ Blue discovers a material misrepresentation or omission after issuing coverage, AZ Blue may rescind the contract and declare it null and void as of the effective date of coverage, or adjust my premium rate to the rate I should have paid based on accurate information, retroactive to the effective date of coverage.
 - coverage will be effective only after AZ Blue has accepted and reviewed this form and assigned an effective date.
 - coverage will be subject to the benefits, limitations, and provisions of the AZ Blue benefit plan, regardless of any other coverage I may have had in the past.
- III.** I acknowledge that I have received an Outline of Coverage for AZ Blue's Senior Security and Senior Preferred plans.
- IV.** I acknowledge that I have received a copy of the "Guide to Health Insurance for People with Medicare."
- V.** I understand that:
- AZ Blue sells health and dental coverage products either directly or through independent licensed insurance producers.
 - Commission payments to producers are one of the costs factored into premiums, but AZ Blue's premium calculation is not based on whether a product is sold directly or by a producer.
 - AZ Blue generally pays a commission to the producer of record or permitted assignee until this contract is terminated or the contract holder terminates his/her relationship with the producer or the producer becomes ineligible.

VI. Medicare Select Acknowledgment

If you are enrolling in a Senior Preferred Medicare Select Plan, you acknowledge that you have received the following information and understand the restrictions of the Senior Preferred benefit plan:

- An Outline of Coverage comparing the Senior Preferred Medicare Select benefit plan and premium with the Senior Security benefit plans and premiums, which includes the following:
 - A description of benefits available when Senior Preferred or non-Senior Preferred providers are used
 - A description of coverage for emergency and out-of-service-area care
 - A description of limitations on referrals to non-Senior Preferred providers
 - A description of my right to purchase a Senior Security plan
 - A description of AZ Blue's quality assurance program and complaint and grievance procedures
- A Senior Preferred provider directory

VII. I give permission for AZ Blue to call me at the phone number(s) provided in this form to provide information and/or discuss matters related to any benefit plan that I purchase, as well as health and wellness information that is related to any such benefit plan.

VIII. With my signature below, I represent that the information provided in this transfer form is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage, the Household Discount, and the authorizations I have provided. I have read the Outline of Coverage and the terms, conditions, and authorizations set forth above. I certify that I meet the eligibility requirements set forth in the Outline of Coverage. I alone am responsible for the accuracy and completeness of this form 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.

All members must sign and date the signature box below to indicate agreement with the acknowledgments.

Member's Signature _____	Date ____ / ____ / ____ (M M / D D / Y Y Y Y)
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Producer Information (For Producer use only, if applicable)

Producer Name (First/Middle Initial/Last) Kevin J Michaels	
Producer NPN (required) 6722372	
Producer Email Address kmichaels@crestins.com	
Producer Fax Number	
Producer Phone Number 480-963-5509	
Today's Date (required) / /	Producer Signature (required)