2025

Blue Cross Medicare Supplement℠

Enrollment Application

READY TO HELP

Plans A, C, D, F, High-Deductible F, G, High-Deductible G and N

2025 Medicare supplement application

1 Applicant information

Please print in black or blue ink. All sections must be completed unless otherwise indicated. All information provided will be used and disclosed only as permitted by our *Notice of Privacy Practices,* which can be found at **bcbsm.com**. We only use your information for understanding and processing your application. All information you provide is confidential.

First name	Middle initial	Last name	Social Security number

Residential street address (cannot be a P.O. Box)	City	State	ZIP code

Mailing street address (if different from above)	City	State	ZIP code

County	Phone number	☐ Home ☐ Cell	Alternate number (optional)	☐ Home ☐ Cell

Email	☐ Male ☐ Female	Date of birth

Medicare number	Part A start date	Part B start date

Number of months you live in MI each year	You don't have to answer this question if you're in your Medigap open enrollment period or have a guaranteed issue right (refer to Sections 5 and 6 of this application for details). Have you used nicotine in any form (including, but not limited to, cigarettes, e-cigarettes, vaping and nicotine patches or gum) in the past year? ☐ **Yes** ☐ **No**

Did you have a Blue Cross Medicare Supplement or Legacy Medigap plan that ended in the past twelve months? ☐ **Yes** ☐ **No**	If **yes**, enrollee ID number:

Household discount eligibility

You may be eligible for a lower premium if another person in your household currently has a Blue Cross Medicare Supplement or Legacy Medigap plan. Household is defined as a single-family home, a condominium unit or an apartment unit within an apartment complex.

Please check the box below that applies to you:

☐ I live with a person who's currently covered under a Blue Cross Medicare Supplement plan or Legacy Medigap plan.

Name of that person (answer required) _____

Enrollee ID number[1] of that person (answer required) _____

☐ I live with a person who is in the process of applying for a Blue Cross Medicare Supplement plan.

Name of that person (answer required) _____

Social Security number of that person (answer required) _____

☐ I don't currently live with another person who has a Blue Cross Medicare Supplement plan or Legacy Medigap plan, and I'm not eligible for the household discount.

Only members with a Blue Cross Medicare Supplement or a Legacy Medigap plan are eligible for a household discount and must live with another eligible person.

Members with Medicare Advantage plans from Blue Cross or Blue Care Network, or Blue Care Network's MyBlue℠ Medigap plans aren't eligible for this discount.

[1]Enrollee ID number is on the Blue Cross member ID card.

2 Plan selection

Please check the appropriate box for the plan you want:

☐ Plan A ☐ Plan C ☐ Plan D ☐ Plan F ☐ Plan HD-F ☐ Plan G ☐ Plan HD-G ☐ Plan N

Please note that HD means high-deductible plan.

When choosing a plan, it's important to know the following:

- **If you turned 65 years old, or became Medicare-eligible on or after January 1, 2020**, you can't enroll in a plan that covers the Part B deductible (plans C, F and High-Deductible F).
- **If you're younger than 65**, you're eligible to enroll in plans A and D only.
- If you had a Medicare supplement plan, then enrolled in a Medicare Advantage plan, and now would like to return to your prior Medicare supplement plan, you must do so within 12 months of enrolling in your Medicare Advantage plan.
- You must be enrolled in Medicare parts A and B.
- You can't have more than one Medicare supplement plan.
- You can't be enrolled in a Medicare supplement plan and a Medicare Advantage plan at the same time.
- At the time of enrollment, you must be a permanent resident of Michigan and physically live in Michigan for at least six months of the year.
- Once enrolled, if you permanently move outside Michigan or live in Michigan for fewer than six months of every year, your premium may change.
- Coverage will only continue if all other eligibility requirements continue to be satisfied. For more information see the *Outline of Coverage* at What will a Medicare supplement plan cost me? | BCBSM for the monthly costs and descriptions of each plan.
- All premiums are subject to change annually.

Requested start date: ___ /_01_ /_____

(must be a future date and must not be more than six months past today's date)

3 Blue Cross Medicare Supplement's Dental Vision Hearing Package

The Dental Vision Hearing Package is additional coverage that gives you:

- In-network dental exams, cleanings, X-rays and fluoride treatment at no additional cost
- In-network vision coverage that includes standard lenses every 12 months
- One hearing exam every 12 months and savings of up to 60% off average retail hearing aid prices at a TruHearing® provider

The monthly premium for the Dental Vision Hearing Package is $34.50 in addition to your Blue Cross Medicare Supplement premium.

New Blue Cross Medicare Supplement members can add the Dental Vision Hearing Package at the time of their initial enrollment or within the first 30 days following their policy start date.

For new members who sign up for a Blue Cross Medicare Supplement plan and the Dental Vision Hearing Package at the same time, **coverage will begin on the same day**.

For new members who sign up for the Dental Vision Hearing Package within the first 30 days following their Blue Cross Medicare Supplement policy start date, **coverage will start the first of the month after the application is accepted. Please note:** applications must be received within the first 30 days of a member's policy start date.

Conditions of enrollment

By choosing to add the Dental Vision Hearing Package, I confirm that I will have an active Blue Cross Medicare Supplement plan and will not have dental, vision or hearing coverage through another individual plan. I agree to add the Dental Vision Hearing Package, which is in addition to my monthly Medicare supplement plan premium. I understand that the premium of $34.50 for the Dental Vision Hearing Package is subject to change each year, and I'll be provided with written notice 30 days prior to any change. I understand that the additional coverage is subject to the terms and conditions stated in my plan certificate. I understand that my signature (or the signature of the person authorized to act on my behalf under the laws of the state of Michigan) on this application means that I've read and understand its contents. If signed by an authorized individual, this signature certifies that this person is authorized under state law to complete this enrollment, and documentation of this authority is available upon request by Blue Cross Blue Shield of Michigan.

☐ I'm choosing to add the Dental Vision Hearing Package to my Blue Cross Medicare Supplement plan for an additional monthly cost.

☐ I decline to add the Dental Vision Hearing Package to my Blue Cross Medicare Supplement plan.

The Dental Vision Hearing Package is only available in conjunction with a Blue Cross Medicare Supplement plan. You can't have dental, vision or hearing coverage through another individual plan.

Paying your plan premium

The premium for the Dental Vision Hearing Package will be added to your monthly Medicare supplement plan premium and paid through the method you choose in Section 9 of this application.

4 Medicaid information

If you're 65 or older, you may be eligible for benefits under Medicaid, and may not need a Medicare supplement plan.

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

Note: If you're participating in a spend-down program and haven't met your out-of-pocket cost maximum, please answer "No" to this question.

If "**Yes,"** Will Medicaid pay your premiums for this Medicare supplement plan? ☐ **Yes** ☐ **No**

Do you receive any benefits from Medicaid other than payment toward your Medicare Part B premium? ☐ **Yes** ☐ **No**

If, after purchasing a Medicare supplement plan, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement plan may be suspended 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're no longer entitled to Medicaid, your suspended Medicare supplement plan may be available. If it's no longer available, a substantially equivalent plan will be reinstated 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 re-instituted policy won't have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5 Open enrollment period

Your Medigap open enrollment period begins on the first day of the month in which you're both age 65 or older **and** enrolled in Medicare Part B. This enrollment period lasts six month.

A. Will you be 65 or older by (or on) the **first** day of the month following your start date?

☐ **Yes** ☐ **No,** I'm younger than 65 and eligible for Medicare due to disability or end stage renal disease.

If you answered no and are younger than 65, you're only eligible for plans A and D.

B. Are you turning 65 the same month or **no more than six months prior** to the first day of your requested start month?

☐ **Yes** ☐ **No,** I turned 65 more than six months ago.

C. Is your Medicare Part B effective date the same month or **no more than six months prior** to the first day of the month you requested to start?

☐ **Yes** ☐ **No,** I enrolled in Part B more than six months ago.

6 Guaranteed issue rights

Guaranteed issue, or GI, rights means you can't be turned down for Medicare supplement coverage or pay a higher premium for preexisting health conditions when you enroll within your Medigap Open Enrollment Period (OEP) or have a guaranteed issue right, all of which are listed below (A through F).

A. Do you have another active Medicare supplement policy? ☐ **Yes** ☐ **No**

If so, name the company and the plan.

_____

If so, do you intend to replace your current Medicare supplement policy with this policy?

☐ **Yes** ☐ **No** (If no, you aren't eligible for this Medicare supplement plan.)

If the Medicare supplement plan has ended or will have ended when this plan starts, why did it end?

☐ Through no fault of my own

☐ Company misled me or failed to follow the rules

☐ Other

B. Have you lost or are you losing other health coverage, or have you received a notice from your previous health plan saying you're eligible for guaranteed issue of a Medicare supplement plan or that you had certain rights to buy a guaranteed issue plan?

☐ **Yes** Start date _____

End date (if you're still covered under this plan, leave the end date blank): _____

Reason for disenrollment: _____

☐ **No**

C. Are you enrolled, or were you previously enrolled, in a **Medicare Advantage plan**?

☐ **Yes** Start date: _____ ☐ **No**

End date (if you're still covered under this plan, leave the end date blank): _____

If "Yes," name of the carrier:_____

If "Yes," select the reason you disenrolled or will be disenrolled when this plan becomes effective.

☐ Plan is leaving Medicare.

☐ Plan is no longer offered in my area.

☐ I'm moving out of the plan's service area.

☐ **(Trial right)** You dropped a Medigap policy to join a Medicare Advantage plan (or to switch to a Medicare SELECT policy) for the first time, you've been in the plan for less than a year and you want to switch back.

☐ Voluntary disenrollment.

☐ **(Trial right)** You joined a Medicare Advantage Plan 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.

☐ Company misled me or failed to follow the rules.

☐ Other _____

D. Do you have Original Medicare and a Medicare SELECT policy, and have moved out of the Medicare SELECT policy service area?

☐ **Yes** ☐ **No**

E. Did 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 Advantage HMO or PPO plan)?

☐ **Yes** ☐ **No**

If "Yes", indicate your start and end dates below. If you're still covered under this plan, leave the end date blank. **Start date** _____ **End date** _____

Was this your first time in this type of Medicare plan?

☐ **Yes** ☐ **No**

Did you cancel a Medicare supplement policy to enroll in the Medicare Advantage plan?

☐ **Yes** ☐ **No**

F. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union or individual plan)?

☐ **Yes** ☐ **No** If so, with what company and what kind of policy?

_____

What are your dates of coverage under the other policy? (If you're still covered under the other policy, leave end date blank.)

Start date _____ **End date** _____

If the plan has ended or will end by the effective date of this plan, what is the reason?

☐ My coverage ended for one of these reasons:

- ☐ Death of the policyholder
- ☐ Divorce from the policyholder
- ☐ I became eligible for Medicare and am no longer eligible for the plan
- ☐ My employer no longer offers group coverage

☐ I voluntarily canceled my coverage due to cost, benefits or another reason.

Important note: If you're currently enrolled in a Medicare Advantage plan and want to enroll in Medicare supplement, you must separately disenroll in writing from Medicare Advantage. Submission of this application doesn't automatically disenroll you from your current Medicare Advantage insurance carrier. Call your Medicare Advantage customer service department for information on how to disenroll from that plan and prevent duplication of coverage or a lapse in coverage. Medicare Advantage plans only allow disenrollment certain times of the year.

If you indicated your employer or group health plan coverage is ending (through no action of your own), or that you received a notice from a prior heath plan that you have a right to buy a GI plan, scan and email a copy of the termination or GI notice to **MedSuppUnderwriting@bcbsm.com** or fax it to **1-877-205-6651**. Be sure your first and last name are clearly legible on the email or fax.

7 Conversion rights (for plans A, C and D)

Have you lost, or will you lose, coverage under a group policy after becoming eligible for Medicare?

☐ **Yes** ☐ **No**

If yes, what is the date you lost, or will lose, coverage? _____

Note: You aren't eligible to enroll in Plan C if you became 65 or qualified for Medicare due to age, disability or end stage renal disease on or after January 1, 2020.

If you're applying for plans A, C or D, you must submit proof that you've lost coverage under a group policy after becoming eligible for Medicare.

8 Health information (for nonguaranteed issue only)

Complete this section only if you are applying outside of your Medigap open enrollment period or don't have a guaranteed issue right.

The information you provide is confidential and will be used and disclosed only as permitted by our *Notice of Privacy Practices*, which can be viewed online at **bcbsm.com**.

Height: _____ ft. _____ in. Weight: _____ lbs.

A. Do any of these apply to you? Please check all that apply.

- ☐ Amyotrophic lateral sclerosis (Lou Gehrig's disease)
- ☐ Cardiomyopathy
- ☐ End stage renal disease (ESRD), chronic kidney disease, currently receiving or may require dialysis
- ☐ Leukemia, lymphoma, malignant melanoma
- ☐ Organ, bone marrow or stem cell transplant
- ☐ Stroke or TIA (mini stroke)
- ☐ Cirrhosis of liver
- ☐ Hemophilia
- ☐ **None of these apply**

Within the past two years, has a medical professional discussed any of the following treatment options that haven't yet been addressed? Please check all that apply.

- ☐ Hospital admittance as an inpatient
- ☐ Organ transplant
- ☐ Back or spine surgery
- ☐ Joint replacement
- ☐ Surgery, radiation or chemotherapy for cancer
- ☐ Heart or vascular surgery
- ☐ **None of these apply**

B. Have you been diagnosed or treated (including taking medication) for any of the following conditions in the past five years? Please check all that apply.

- ☐ Angina, coronary artery disease, heart attack, congestive heart failure, artery/vein blockage, implantation of pacemaker, peripheral vascular disease
- ☐ Chronic obstructive pulmonary disease (COPD), emphysema, any lung or respiratory disorder requiring oxygen
- ☐ Cancer
- ☐ Alzheimer's disease, dementia or any other cognitive disorder
- ☐ Parkinson's disease, multiple sclerosis, systemic lupus erythematosus, rheumatoid arthritis
- ☐ Diabetes with circulatory or kidney problems or retinopathy
- ☐ Crohn's disease, ulcerative colitis
- ☐ Major depression
- ☐ **None of these apply**

C. Do you have any of the following health conditions? Please check all that apply.

- ☐ Atrial fibrillation, cardiac arrhythmia
- ☐ Asthma, sleep apnea
- ☐ Diabetes (well controlled with no complications)
- ☐ Glaucoma, macular degeneration
- ☐ Hypertension (high blood pressure)
- ☐ Hyperlipidemia (high cholesterol)
- ☐ Osteoporosis with fractures, arthritis that restricts mobility or activities of daily living
- ☐ **None of these apply**

List medications you've taken in the last 12 months (if more room is needed, please list on a separate page and attach to your application):

Authorization for protected health information, also called PHI, use and disclosure (required if applying outside your open enrollment or Medigap open enrollment period or don't have a guaranteed issue right).

I understand that the following parties may need to collect information about me in regard to the proposed coverage: Blue Cross Blue Shield of Michigan and its reinsurers, any insurance support organization, any consumer reporting agency and all persons authorized to represent these organizations for this purpose.

Any and all individually identifiable health information, including, but not limited to medical records, reports, pharmaceutical records, diagnostic testing and lab work results may be disclosed to or by Blue Cross Blue Shield of Michigan. This medical or health information may include information on the diagnosis and treatment of mental illness, alcohol and drug use. This also may include information on the diagnosis, treatment and testing results related to HIV, AIDS and sexually transmitted diseases, unless otherwise restricted by state law.

Those parties that need to collect information may disclose information to the following: other insurers to whom I've applied or may apply; reinsurers, pharmacy benefit managers, physicians, hospitals, clinics or other medically related facilities; health care clearinghouses; or persons who perform business, professional or insurance tasks for them. They may disclose information as allowed or required by law.

I understand that this authorization is needed for the purpose of gathering information for making eligibility and underwriting determinations. Unless revoked earlier, this authorization will be valid for 30 months after the date signed.

I understand I can revoke this authorization any time by giving written notice on a standard form available online at **bcbsm.com**, or by contacting my agent. I also understand that my revocation won't affect the rights of any individual who has acted in reliance on the authorization prior to receiving notice of my revocation.

I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization, but if I refuse, I may not be eligible for enrollment. I understand there is a possibility of redisclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality. Failure to sign this authorization, or subsequent revocation of this authorization may impair the ability of Blue Cross Blue Shield of Michigan to process my application or evaluate claims, and may be a basis for denying a claim for benefits; however my ability to receive health care services will not be changed if I do not sign this authorization.

Applicant printed name (must match the name as entered in Section 1 of this application)	
Applicant signature	Date

9 Payment information

Choose one:

☐ Receive a monthly bill and pay by mail ☐ Electronic funds transfer from your bank account each month

If you selected electronic funds transfer, on the due date for each bill, the checking or savings account you designate will be debited for the amount of your premium.

Once enrolled, you can request a monthly statement or get more information about your automatic bill payment plan by calling Customer Service at **1-888-216-4858**, from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users, call **711**.

Name of financial institution		Account type ☐ Checking ☐ Savings
ABA/routing number and attach copy of a voided check		Account number
Printed name of the account holder	Signature of the account holder	Date
Email address		

Additional information

You don't need more than one Medicare supplement plan.

- If you purchase this plan, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- If you're eligible for, and have enrolled in, a Medicare supplement plan because of a 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 have coverage 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 re-instituted 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 re-instituted policy won't have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Your coverage will automatically be renewed each year as long as you pay your premiums.
- To terminate your Blue Cross Medicare Supplement plan, please notify Blue Cross Blue Shield of Michigan in writing or call Customer Service at **1-888-216-4858**, from 8 a.m. to 5 p.m. Eastern time, Monday through Friday. TTY users, call **711**.
- Counseling services may be available in your state to provide advice about your purchase of Medicare supplement insurance and Medicaid.

10 Confirm and sign

Please read, sign and date where indicated.

My signature indicates that I've read and understand the contents of this application. I declare that the answers on this application are complete and true to the best of my knowledge and belief, and are the basis for issuing coverage. I understand that the application and amendments become a part of the contract and that if the answers are incomplete, incorrect or untrue, Blue Cross Blue Shield of Michigan may have the right to rescind my Blue Cross Medicare Supplement coverage or adjust my premium. I understand that I may not be eligible for all offered plans, and confirm that I haven't applied for any plan for which I'm not eligible.

If I cancel within the first 30 days of the effective date of this coverage, I'll be entitled to a refund of my previous premium payment. Please note that the reasonable costs for any health services paid by Blue Cross during that time period will be deducted from the refund and I will be responsible for payment of reasonable fees for any health care services I received. If I choose to cancel my coverage after the first 30 days, I understand I must write or call Blue Cross' Customer Service department.

Any person who knowingly, and with intent to defraud any health plan company or other person, files an application or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent act when determined by a court of competent jurisdiction, and as such may be subject to criminal and civil penalties. I understand the coverage under the plan I'm applying for won't take effect until issued by Blue Cross Blue Shield of Michigan. Blue Cross Blue Shield of Michigan requires proper handling of personal health information for its members. Details of Blue Cross Blue Shield of Michigan's confidentiality policies and procedures are available at **bcbsm.com**.

☐ **Yes** ☐ **No** I have received a copy of the Blue Cross Medicare Supplement plan *Outline of Coverage*.

☐ **Yes** ☐ **No** I have received a copy of *Choosing a Medigap Policy*.

Applicant's printed name (must match name as entered in Section 1 of this application)	Applicant's signature	Date

You will receive an ID card with a letter confirming your start date and premium. A *Certificate of Coverage* will be made available to you.

If you're the authorized personal representative, or have an authorized representative currently on file with Blue Cross, you must provide the following information:

Personal representative's printed name			
Personal representative's signature		Date	
Street address	City	State	ZIP code
Phone	Relationship to applicant		

Applications can be submitted in the following ways:

Online: For Members: Medicare Enrollment Forms | BCBSM

Fax: 1-866-392-7528

Mail: Blue Cross Blue Shield of Michigan
P.O. Box 44407
Detroit, MI 48244-0407

Agents must submit applications online at **bcbsm.com/agents**.

11 For agent use only

Enrolling an individual in a Medicare supplement plan requires that you provide the following information:

1. Have you sold any other health plan policies to this individual that are still in force?
   - ☐ **Yes** Policy descriptions (name of policy, policy number, start date):

     _____

   - ☐ **No**
2. Have you sold any health plan policies to this individual in the last five years that aren't still in force?
   - ☐ **Yes** Policy descriptions (name of policy, policy number, start and end dates):

     _____

     _____

   - ☐ **No**
3. Did you ask the applicant all the questions in this application and record the answers as given to you?
   - ☐ **Yes**
   - ☐ **No**

Managing agent / general agency name (if applicable)		MA/GA two-digit code
Email address	Primary phone	Fax
Agent's first and last name		Agent five-digit code
Agent's signature		Date agent accepted application
Name of person who entered application online	Blue Cross badge ID E_____ or C_____	Blue Cross source code

Applications must be submitted online at **bcbsm.com/agents** or submitted to the managing agent or general agent within 24 hours of accepting the applicant's paper application.

12 Notice to applicant

Notice to applicant about replacement of Medicare supplement coverage

Blue Cross Blue Shield of Michigan
600 East Lafayette Boulevard
Detroit, Michigan 48226

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

According to your application or the information you furnished, you intend to drop or otherwise terminate existing Medicare supplement coverage or a Medicare Advantage plan and replace it with a new certificate to be issued by Blue Cross Blue Shield of Michigan. Your new certificate provides 30 days within which you may decide, without cost, whether you want to keep the certificate.

You should review this new coverage carefully, comparing it with all disability and other health coverage you now have. You should terminate your present coverage only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

Statement to applicant by Blue Cross' Medicare supplement agent, broker or other representative:

I've reviewed your current medical or health coverage as disclosed to me. The replacement of coverage involved in this transaction doesn't 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, to the best of my knowledge. The replacement plan is being purchased for the following reason (check one):

☐ Additional benefits

☐ No change in benefits, but lower premiums

☐ Fewer benefits and lower premiums

☐ Enrolling in Part D and current plan has drug coverage

☐ Disenrollment from a Medicare Advantage plan

Reason for disenrollment _____

☐ Other (please specify) _____

☐ **Didn't replace existing Medicare supplement coverage**

If, after thinking about it carefully, you still wish to drop your present coverage 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 important medical information on an application may provide a basis for the insurer to deny any future claims and refund your premium as though your policy or certificate had never been in force. Before you sign your completed application, review it carefully to be certain that all information has been properly recorded.

Don't cancel your present policy until you've received your new certificate and are sure you want to keep it.

Please select the option below that applies to you:

☐ The *Notice to Applicant* was delivered to me on (date): _____

☐ I delivered this *Notice to Applicant* to the applicant on (date): _____

Signature of agent, broker or other representative (signature not required for direct response sales)		Date	
Printed name of agent		Agent number	
Agent's street address	City	State	ZIP code

Applicant's signature		Date	
Printed name of applicant			
Applicant's street address	City	State	ZIP code
Policy, certificate or contract number being replaced			

Notes

Notes

Blue Cross
Blue Shield
of Michigan

A nonprofit corporation and independent licensee
of the Blue Cross and Blue Shield Association

bcbsm.com/medicare/plans/supplement/

This is a solicitation of insurance. We may contact you about buying insurance. Blue Cross Medicare Supplement plans aren't connected with or endorsed by the U.S. government or the federal Medicare program.