SISC/Blue Cross Medicare Supplemental Coverage

Claim-Free Companion Care Application Form

For District Use Only
GROUP MEDICAL NO.
EFFECTIVE DATE

Application Information - Applicant must complete this section.

Name (Last) (First) (M) | Social Security Number

☐ Male ☐ Female | Date of Birth (Month/day/year) ____/ ____/____

Home Address, Apt. No., Suite No. City State Zip

Care of/Attention | Home Telephone Number

Billing Address (If Different from Home Address)

If transferring from another Blue Cross group or Blue Cross plan, indicate:

Group Number | Subscriber ID Number | Headquarters: City State Zip

I am covered under Medicare for: ☐ Hospital Part A ☐ Medical Part B
I am not currently covered under Medicare Parts A & B ☐ I will be effective on ____/ ____/____

Medicare Beneficiary ID Number Required | **(Please Attach a Photocopy of Your Medicare ID card)**

I understand that the following conditions apply as a part of this coverage:

A. Health conditions which you may presently have (pre-existing conditions) will be covered immediately for retirees transferring directly from a current SISC/Blue Cross medical plan.

B. If a retiree transfers to a SISC/Blue Cross Medicare Supplemental Plan the retiree may not transfer back to a regular SISC/Blue Cross plan.

C. If your doctor does not accept Medicare Assignment, you will be responsible for the difference between the Medicare allowable charge and the doctor's billed charges.

D. Coverage under this policy will be effective on the first day of the month following a period of 30 days after the application and initial premium payment are received.

Signature ______________________________ Date ____________________

Authorization to Receive and Release Medical Information

I authorize the U.S. Department of Health and Human Services (including the Centers of Medicare & Medicaid Services, formerly called HICFA), any physician, or other health care professional, hospital or other health care facility, counselor, therapist or any other medical or medically related facility or professional, to give Blue Cross of California or its affiliates, agents, employees, designees or representatives, including my Blue Cross agent or broker any and all information or records relating to the medical history, medical examinations, services rendered, or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, A.I.D.S. (Acquired Immune Deficiency Syndrome) or A.R.C. (AIDS-related Complex). I understand that California law prohibits an HIV test being required or used as a condition to obtaining medical coverage.

I also authorize Blue Cross of California or its agents or its designees or representatives, to disclose to a hospital or health care service plan, self-insurer, any such medical information obtained if such a disclosure is necessary to allow the processing of any claim. This authorization shall become effective immediately and shall remain in effect as long as is necessary to enable Blue Cross of California to process claims. A photocopy of this authorization shall be as valid as the original.

Signature ______________________________ Date ____________________