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 Filing Company: Group Hospitalization and Medical Services, Inc. State Tracking Number:
 Company Tracking Number: SUDMVAAP (1/12)
 TOI: MS08I Individual Medicare Supplement - Sub-TOI: MS08I.012 Multi-Plan 2010
 Standard Plans 2010
 Product Name: Supplement-65
 Project Name/Number: SUDMVAAP (1/12)/SUDMVAAP (1/12)

Form Schedule

Lead Form Number: SUDMVAAP (1/12)

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	SUDMVAA P (1/12)	Application/ Enrollment Form	Supplement-65 Application	Initial			SUDMVAAP 1-12.pdf

Supplement-65 Application

District of Columbia Residents
Coverage designed to supplement benefits under Medicare

**For assistance completing this application,
CALL 1-800-275-3802**



Group Hospitalization and Medical Services, Inc.
840 First Street, NE, Washington, DC 20065

INSTRUCTIONS

1. Please fill out all applicable spaces on this application. Print or type all information.
2. Sign this application on page 11 and return it in the postage-paid envelope, if provided. Or mail to:
**CareFirst BlueCross BlueShield
Mailroom Administrator
P.O. Box 14651
Lexington, KY 40512**
3. **Send no money with this application.** You will be notified by mail of the amount due if this application is accepted.
Give careful attention to all questions in this application. Accurate, complete information is necessary before your application can be processed. If incomplete, the application will be returned and delay your coverage.

PLEASE CORRECT ANY INCORRECT NAME OR
▼ ADDRESS INFORMATION BELOW ▼

Last Name			First Name			Middle Initial		
Residence Address (Number and Street)								
City			State			Zip Code		

Note: Please consider retaining your existing plan coverage until it is determined that you have passed Medical Underwriting.

SECTION 1. APPLICANT INFORMATION ▼

1A. PERSONAL INFORMATION

Social Security (or Railroad Retirement) Number: _____ - _____ - _____		Date of Birth: _____ / _____ / _____ Month Day Year	
Billing Address (if different from Resident Address): Number and Street:			
City:		State:	Zip Code (9-Digit if known):
Did you establish permanent residence at the above address within the last 31 days? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	Home Phone ()		Height: _____ ft. _____ in. Weight: _____ lbs.

1B. PLAN OPTIONS

Please check the Supplement-65 Plan for which you are applying (check only one plan):

PLAN A* **PLAN B** **PLAN F** **High Deductible PLAN F** **PLAN N**

**If you are under age 65 and have Medicare, you may apply for PLAN A only.*

CareFirst BlueCross BlueShield is the business name of Group Hospitalization and Medical Services, Inc. and is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ® Registered trademark of CareFirst of Maryland, Inc.

SECTION 1. APPLICANT INFORMATION (CONTINUED) ▼

1C. EFFECTIVE DATE

Your coverage becomes effective on the first day of the month following receipt and approval of this application. You will receive a Policy confirming the following effective date.

Requested Effective Date of Coverage: _____ / _____ / _____
Month Day Year

SECTION 2. MEDICARE COVERAGE INFORMATION ▼

Please provide the following Medicare Information as printed on your red, white and blue Medicare identification card. **You must have both Medicare Part A (hospital) and Medicare Part B (medical/surgical) coverage or will obtain Medicare coverage before the effective date of this Supplement-65 Policy.**

Health Insurance Claim Number:

Medicare Hospital (**PART A**) Effective Date:
_____/_____/_____
Month Day Year

Medicare Medical/Surgical (**PART B**) Effective Date:
_____/_____/_____
Month Day Year

SECTION 3. ELIGIBILITY INFORMATION ▼

You are eligible to enroll if all of these are true:

- You are enrolled in Medicare Parts A & B,
- You are not duplicating Medicare Supplement Coverage.

Note: If you are not yet age 65, you may enroll within 6 months after either: 1) enrolling in Medicare Part B; or 2) terminating from the Maryland Health Insurance Plan as a result of your enrollment in Medicare Part B (you **must** include evidence of termination from the Maryland Health Insurance Plan along with your enrollment form). If you meet either of these requirements, you may only enroll in Plan A.

Please answer the following question regarding your eligibility:

3A. Did you turn age 65 in the last 6 months?..... Yes No

3B. Did you enroll in Medicare Part B within the last 6 months?..... Yes No

3C. At the time of this application, are you within 6 months from the first day of the month in which you first enrolled or will enroll in Medicare Part B? Yes No

Note: If you answered YES to 3A, 3B, or 3C, your acceptance is guaranteed. Skip Section 4 and go directly to Section 5. If you answered **NO** to **3A, 3B AND 3C**, continue to question **3D**.

3D. Please refer to the Guaranteed Issue Guidelines in Section 9 of this application (page 12).

Have you lost other health insurance coverage and are now eligible for guaranteed issue based on the provisions in Section 9: Guaranteed Issue?..... Yes No

If you checked YES and are eligible for guaranteed issue, attach a copy of your termination notice, HIPAA certificate, or other correspondence to validate your eligibility for guaranteed issue. Skip to Section 5.

If you answered NO to all questions in this section, continue to Section 4.

SECTION 4. HEALTH EVALUATION ▼

Please complete Sections 4A, 4B, 4C, 4D and 4E. Check each item “Yes” or “No.”

Have you had a physical exam within the past 5 years? Yes No

Have you used tobacco products within the last 5 years? Yes No

4A. PLEASE ANSWER THE FOLLOWING HEALTH QUESTIONS TO HELP DETERMINE WHETHER OR NOT YOU ARE ELIGIBLE.

To the best of your knowledge and belief, in the last five years, have you consulted a physician, licensed medical provider, been diagnosed, treated, OR advised to have treatment for:

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” OR YOUR APPLICATION WILL BE RETURNED.

1. Cancer (except skin or thyroid)..... Yes No
2. Melanoma, Hodgkin’s Disease, Leukemia, or Multiple Myeloma Yes No
3. Kidney Disease or Disorder: Including Kidney Failure, Kidney Dialysis Yes No
4. Amyotrophic Lateral Sclerosis or Anterior Horn Disease..... Yes No
5. Alzheimer’s, Senile Dementia, or other organic brain disorders, including alcoholic psychosis Yes No
6. An Organ Transplant (kidney, liver, heart, lung, or bone marrow), or are on a waiting list for a transplant Yes No
7. Have you tested positive for exposure to the HIV infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection, or other sickness or condition derived from such infection?..... Yes No



If you answered **YES** to any of the questions in this Section 4A, you are **NOT** eligible for these plans at this time. If your health status changes in the future, allowing you to answer NO to all of the questions in this section, please submit an application at that time. For information regarding plans that may be available, contact your local state department on aging.

If you answered **NO** to **ALL** the questions in Section 4A, please continue to Section 4B.

4B. MEDICATIONS

If you are presently using or have used medication or prescription drugs in the past 12 months (1 year), please provide details below. If more space is needed, attach a separate sheet of paper.

Illness or Condition:	Medication:	Dosage:	How Often Taken:
Date of Last Treatment: _____/_____/_____	Attending Physician Name and Address:		
Illness or Condition:	Medication:	Dosage:	How Often Taken:
Date of Last Treatment: _____/_____/_____	Attending Physician Name and Address:		
Illness or Condition:	Medication:	Dosage:	How Often Taken:
Date of Last Treatment: _____/_____/_____	Attending Physician Name and Address:		

SECTION 4. HEALTH EVALUATION (CONTINUED) ▼

4C. HEALTH QUESTIONNAIRE

To the best of your knowledge and belief, in the last five years, have you consulted a physician, licensed medical provider, been diagnosed, treated, OR advised to have treatment for:

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” OR YOUR APPLICATION WILL BE RETURNED.

- 1. Insulin Dependent Diabetes Mellitus (Diabetes for which you take Insulin) Yes No
- 2. Liver Disease or Disorder: including Cirrhosis of Liver, Hepatitis C..... Yes No
- 3. Lung Disease or Disorder: including Chronic Obstructive Pulmonary Disease, Emphysema or required use of oxygen therapy to assist in breathing Yes No
- 4. Heart or circulatory surgery of any type, including angioplasty, bypass, stent placement or replacement, valve placement or replacement Yes No
- 5. Heart conditions including congestive heart failure, heart attack, cardiomyopathy, heart rhythm disorders including pacemakers or defibrillator Yes No
- 6. Coronary Artery Disease (CAD) including hypertension or cholesterol Yes No
- 7. Stroke (CVA)..... Yes No
- 8. Transient Ischemic Attack (TIA) Yes No
- 9. Multiple sclerosis, Parkinson’s Disease, Muscular Dystrophy or paralysis of any type... Yes No
- 10. Auto Immune conditions including Systemic Lupus, Scleroderma, other connective tissue conditions..... Yes No
- 11. Nervous or Mental Disorder requiring psychiatric care or hospitalization, including substance or alcohol abuse Yes No
- 12. Thyroid cancer Yes No

4D. ADDITIONAL HEALTH QUESTIONS

Please answer the following questions regarding your most recent medical history, to the best of your knowledge and belief.

NOTE: ALL QUESTIONS MUST BE CHECKED “YES” OR “NO” OR YOUR APPLICATION WILL BE RETURNED.

- 1. Are you currently hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or received home health care in the last 90 days? Yes No
- 2. Have you been advised by a medical practitioner that you will need to be hospitalized, bedridden, confined to a nursing facility, require the use of a wheelchair, or receive home health care within the next six months?..... Yes No
- 3. Have you been advised by a medical practitioner to have surgery within the next six months? Yes No
- 4. Have you had medical tests in the last year for which you have not yet received results? Yes No

5. Date of last hospitalization and condition requiring hospitalization

Duration Dates: From: _____/_____/_____ To: _____/_____/_____

Condition: _____

SECTION 4. HEALTH EVALUATION (CONTINUED) ▼

4E. EXPLANATION OF DIAGNOSIS AND TREATMENTS

If you have checked “Yes” to any part of SECTION 4C or 4D, for each box checked, please provide complete information regarding diagnosis or condition, treatment (including all medications, hospitalizations, surgeries and diagnostic testing results) and dates. If more space is needed, attach a separate sheet of paper.

Question Number	Diagnosis or Condition	Duration Dates	Explain treatment (including all medications, hospitalizations, surgery and diagnostic test results and physician/hospital name)	Recovery (check one box)
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial
		From: To:		<input type="checkbox"/> Full <input type="checkbox"/> Partial

SECTION 5. PAST AND CURRENT COVERAGE ▼

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

- You do not need more than one Medicare supplement insurance 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 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 reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

SECTION 5. PAST AND CURRENT COVERAGE (CONTINUED) ▼

- 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 policy is no longer available, a substantially equivalent policy) will be reinstated 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 reinstated 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 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 through the state Medicaid program, including benefits as a Qualified Medical Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

For your protection, you are required to answer all of the questions below (5A through 5M).

Please Note: If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying 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 from your prior insurer with your enrollment form.

5A. Did you turn age 65 in the last 6 months? Yes No

5B. Did you enroll in Medicare Part B in the last 6 months? Yes No

5C. If Yes, what is the effective date? _____ / _____ / _____

5D. Are you covered for medical assistance through the State Medicaid program? (Medicaid is not the same as Federal Medicare. Medicaid is a program run by the state to assist with medical costs for lower or limited-income people.) Yes No
 If **NO**, skip to question **5G**.
 If **YES**, continue to **5E** and **5F**.

5E. Will Medicaid pay your premiums for this Medicare supplement policy? Yes No

5F. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

5G. Have you had 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)? Yes No
 If **NO**, skip to question **5K**.
If YES, fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
 START _____ / _____ / _____ END _____ / _____ / _____

5H. 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

5I. Was this your first time in this type of Medicare plan? Yes No

5J. Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No

SECTION 5. PAST AND CURRENT COVERAGE (CONTINUED) ▼

5K. Do you have another Medicare supplement policy in force? Yes No

If **NO**, skip to question **5M**.

If **YES**, indicate the company and plan name (i.e. Medigap Plan A, B, etc.) and then continue to **5L**.

Company Name _____

Plan Name _____

5L. Since you have another Medicare supplement policy in force, do you intend to replace your current Medicare supplement policy with this policy? Yes No

5M. Have you had coverage under any other health insurance within the past 63 days? .. Yes No

If **NO**, continue to Section 6.

If **YES**:

What company and what kind of policy?

Company Name _____

Membership number IF a CareFirst BlueCross BlueShield Policy _____

Policy Type: HMO/PPO Major Medical Employer Plan

Union Plan Other

What are you dates of coverage under the policy listed in 5M? (If you are still covered under the other policy, leave "END" blank.)

START ____/____/____ END ____/____/____

6. PREMIUM PAYMENT

CareFirst BlueCross BlueShield's standard method of payment for members is automated payment via bank withdrawal. Please provide the following information so that we may establish your automated payment.

Checking Account Savings Account

Bank Name:

Bank Routing Number:

Bank Account Number:

Name that appears on the Account:

NAME
ADDRESS
CITY, STATE ZIP

0123
01-23456789

DATE _____

PAY TO THE ORDER OF _____ \$ _____

_____ DOLLARS

BANK NAME
ADDRESS
CITY, STATE ZIP

FOR _____

⑆012345678⑆ 0123456789012⑆ 0123

Bank Routing Number Bank Account Number Check Number

I hereby authorize CareFirst BlueCross BlueShield to charge my account for the payment of premiums due for an unpaid invoice. If any check draft is dishonored for any reason, or drawn after the depositor's authorization has been withdrawn, CareFirst agrees that the financial institution will not be held liable. I understand that non-payment of premiums due to dishonored auto-draft payment attempts may result in termination of coverage. I also understand that if the Policyholder elects to pay premium through an electronic payment, CareFirst BlueCross BlueShield may not debit or charge the amount of the premium due prior to the premium due date, except as authorized by the Policyholder. My recurring payments will be processed on the 6th of each month (including holidays). Members registered for recurring payment will not receive a paper bill in the mail. However, you may view and print your invoice during the recurring payment period from the invoice history online at www.carefirst.com/myaccount.

Signature of Account Holder: X _____ Date: _____ / _____ / _____

Check this box if you intend to pay by submitting paper checks or by credit card.

SECTION 7. ELECTRONIC COMMUNICATION CONSENT ▼

You can receive electronic notices via email instead of paper notices for your CareFirst BlueCross BlueShield health care coverage by providing your email address and consent below.

These will include but are not limited to:

- Explanation of Benefits alerts
- Appeal decision alerts
- Notice of HIPAA Privacy Practices
- Certification of Creditable Coverage

You may also receive information on programs related to your existing products and services along with new products and services that may be of interest to you.

- You may change your email and consent information anytime by logging into www.carefirst.com/myaccount or by calling the customer service phone number on your ID card.
- You can request a paper copy of electronic notices at anytime by calling the customer service phone number on your ID card.

I understand that to access the information provided electronically, I must have the following:

- Internet access;
- An email account that allows me to send and receive emails; and
- Microsoft Explorer 7.0 (or higher) or Firefox 3.0 (or higher), and Adobe Acrobat Reader 4 (or higher).

By checking this box, I hereby agree to electronic delivery of notices and documents, instead of paper delivery.

Applicant Name	Email Address

CareFirst BlueCross BlueShield will not sell your email to any third party and we do not share it with third parties except for CareFirst BlueCross BlueShield business associates that perform functions on our behalf or to comply with the law.

SECTION 8. CONDITIONS OF ENROLLMENT (PLEASE READ THIS SECTION CAREFULLY) ▼

IT IS UNDERSTOOD AND AGREED THAT:

A copy of this application is available to the Policyholder (or to a person authorized to act on his/her behalf) upon request, from CareFirst BlueCross BlueShield (CareFirst).

This information is subject to verification. To do so I authorize any physician, hospital, pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company including MIB, Inc. to release my "Medical Information" to CareFirst's business associates or representatives. I further authorize any business associate who receives "Medical Information" from any physician, hospital pharmacy, pharmacy benefit manager or pharmacy related service organizations or any other medical or medically-related person or company including MIB, Inc. to release my "Medical Information" to CareFirst. I understand that my Medical Information consists of any diagnoses, treatment, prescriptions from a pharmacy, or any other medically related information about me. I authorize CareFirst to use my Medical Information for underwriting and to determine my eligibility for insurance benefits.

This authorization shall include and apply to any and all protected health information related to treatments where I have requested a restriction to a health care provider to release information and/or for any health care item or service for which I have paid the health care provider in full. I understand this authorization will remain in effect for 30 months from the date signed.

I understand that I have the right to cancel this authorization at any time, in writing, except to the extent that CareFirst has already taken action in reliance on this authorization. I also understand that CareFirst's Notice of Privacy Practices includes information pertaining to authorizations and to requirements of revocation. A copy of the Notice may be obtained by contacting the CareFirst's Privacy Office. CareFirst will not use or disclose the Medical Information for any purposes other than those listed above except as may be required by law. CareFirst is required to tell you by law that information disclosed pursuant to this authorization may be subject to re-disclosure and that under some limited circumstances will no longer be protected by federal privacy regulations.

If CareFirst determines that additional information is needed, I will receive an authorization to release that information. Failure to execute an authorization may result in the denial of my application for coverage. Additionally I understand that failure to complete any section of this application, including signing below, may delay the processing of my application.

To the best of my knowledge and belief, all statements made on this application are complete, true and correctly recorded. They are representations that are made to induce the issuance of, and form part of the consideration for a CareFirst policy. I understand that a medically underwritten policy is only issued under the conditions that the health of all persons named on the application remains as stated above. I also understand that failure to enter accurate, complete and updated medical information may result in the denial of all benefits or cancellation of my policy. CareFirst may rescind or void my coverage only if (1) I have performed an act, practice, or omission that constitutes fraud; or (2) I have made an intentional misrepresentation of material fact. CareFirst will provide 30-days advance written notice of any rescission of coverage and refund any premiums to the Policyholder. The Member is responsible for repayment of any claim payment made by CareFirst on the Member's behalf.

I will update CareFirst if there have been any changes in health concerning any person listed in this application that occur prior to acceptance of this application by CareFirst.

If you have any questions concerning the benefits and services that are provided by or excluded under this Policy, please contact a membership services representative before signing this application.

An applicant or dependent age 19 or older whose application is denied by CareFirst due to medical underwriting may not submit a new application for enrollment within ninety (90) days of the denial.

WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, CAREFIRST BLUECROSS BLUESHIELD MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

SECTION 8. CONDITIONS OF ENROLLMENT (CONTINUED) ▼

Information regarding your insurability will be treated as confidential. CareFirst or its reinsurers may, however, make a brief report thereon to the MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Regarding MIB: Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642) If you question the accuracy of the information in the MIB file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. CareFirst or its reinsurers may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

X _____ Date ____/____/____
Applicant's Signature (PLEASE DO NOT PRINT)

FOR OFFICE USE ONLY:

Re-sign and re-date below only if box is checked.

Signature of Applicant: X _____ Date ____/____/____

FOR BROKER USE ONLY:	Name:	SSN/Tax ID #:	CareFirst-Assigned ID#:
Contracted Broker:			
Sub-Agent/Sub-Agency:			
Writing Agent:			

SECTION 9: GUARANTEED ACCEPTANCE

Open Enrollment:

- Your acceptance in any plan is guaranteed during your Medicare supplement open enrollment period which lasts for 6 months, beginning with the first day of the month in which you are age 65 or older and also enrolled in Medicare Part B.
- If you are under age 65, you are eligible for guaranteed acceptance into Plan A if you enroll within 6 months after either: 1) enrolling in Medicare Part B; or 2) terminating from the Maryland Health Insurance Plan as a result of your enrollment in Medicare Part B (you must include evidence of termination from the Maryland Health Insurance Plan along with your enrollment form).

Other Provisions:

If you lost health insurance coverage, you may be considered an “Eligible Person” entitled to guaranteed acceptance and you may have a guaranteed right to enroll in CareFirst Medicare Supplement Plans under the following circumstances:

WITHIN THE PAST 63 DAY PERIOD YOU WERE ENROLLED UNDER:

1. An employee welfare benefit plan that supplemented Medicare benefits and the plan terminated or ceased to provide you with all of the supplemental health benefits;
2. A Medicare Advantage plan, or you are 65 years of age or older and are enrolled with a Program of All Inclusive Care for the Elderly (PACE) provider under Section 1894 of the Social Security Act, and one of the following occurs:
 - a) The certification of the organization or plan has been terminated, or the organization no longer provides the plan within the service area in which you reside;
 - b) You were unable to continue coverage with the plan because you moved out of the plan’s service area or other change in circumstances specified by the Secretary of the Department of Health and Human Services. This excludes circumstances where you have not paid premiums on a timely basis or engaged in disruptive behavior as specified in standards under Section 1856 of the Social Security Act;
 - c) You can demonstrate that:
 - (1) The organization offering the plan substantially violated a material provision of the organization’s contract, including the failure to provide you with medically necessary care on a timely basis for which benefits are available under the plan or in accordance with applicable quality standards; or
 - (2) The organization, or agent or other entity acting on the organization’s behalf, materially misrepresented the plan’s provisions in marketing the plan to you; or
3. A Medicare supplemental policy and your enrollment ceased because:
 - a) Of any involuntary termination of coverage or enrollment under the policy, including termination caused by insolvency of the issuer or by the bankruptcy of an organization providing the plan;
 - b) The issuer of the policy substantially violated a material provision of the policy; or
 - c) The issuer (or agent or entity acting on the issuer’s behalf) materially misrepresented the policy’s provision in marketing the policy; or

SECTION 9: GUARANTEED ACCEPTANCE (CONTINUED)

4. A Medicare supplement policy and
 - a) Terminated enrollment and subsequently enrolled, for the first time, with:
 - any Medicare Advantage plan;
 - any eligible organization under a contract under Section 1876 (Medicare cost);
 - any similar organization operating under demonstration project authority;
 - any PACE provider, under section 1894 of the Social Security Act;
 - any organization under an agreement under Section 1833(a)(1)(A) (health care prepayment plan) or
 - a Medicare Select policy; and
 - b) The subsequent enrollment was terminated by you during any period within the first 12 months of such subsequent enrollment (during which you were permitted to terminate such subsequent enrollment under section 1851(e) of the federal Social Security Act); or
5. A Medicare Advantage plan, or with a PACE provider under section 1894 of the Social Security Act upon first becoming eligible for benefits under Part A of Medicare at age 65, and disenroll from the plan or program by not later than 12 months after the effective date of enrollment; or
6. Medicare Part D plan, and ALSO were enrolled under a Medicare supplement policy that covers outpatient prescription drugs. When you enrolled in Medicare Part D, you terminated enrollment in the Medicare supplement policy that covered outpatient prescription drug coverage. NOTE: Evidence of enrollment in Medicare Part D must be submitted with this application.

IMPORTANT NOTE:

- You are required to:
 - o Apply within the required time period following the termination of your prior health insurance plan.
 - o Provide a copy of the termination notice you received from your prior insurer with your application
This notice must verify the circumstance of your plan's termination and describe your prior plan's termination and describe your right to guaranteed issue of Medicare Supplement Insurance.
- If you have any question on your guaranteed right to insurance, you may wish to contact the Administrator of your prior health insurance plan or your local state Department on Aging.

SERFF Tracking Number: CFBC-128032219 State: District of Columbia
Filing Company: Group Hospitalization and Medical Services, Inc.State Tracking Number:
Company Tracking Number: SUDMVAAP (1/12)
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Standard Plans 2010
Product Name: Supplement-65
Project Name/Number: SUDMVAAP (1/12)/SUDMVAAP (1/12)

Supporting Document Schedules

Item Status: **Status**
Date:

Satisfied - Item: Submission letter

Comments:

Attachment:

Submission letter.pdf

Item Status: **Status**
Date:

Satisfied - Item: Readability Certification

Comments:

Attachment:

DC Readability Compliance Certification.pdf

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
www.carefirst.com

VIA SERFF
January 26, 2012

William P. White, Commissioner
Department of Insurance, Securities and Banking
810 First Street, NE
Suite 701
Washington, DC 20002



RE: Group Hospitalization and Medical Services, Inc. doing business as
CareFirst BlueCross BlueShield (CareFirst)
NAIC Number: 53007
FEIN: GHMSI 53-0078070
Form Number: SUDMVAAP (1/12), Supplement-65 Application

Dear Commissioner:

Attached for your review and approval is a copy of the above-referenced member enrollment form in its final version. The form will be used in the individual market for our individual market products. This form replaces Form Number SUDMVAAP (8/11), which was approved by your office on 9/14/11.

The form will be included on our website at www.carefirst.com and on the following website at www.ehealthinsurance.com. Please note that in those instances where an applicant is completing an application online, the applicant's signature will only be used for the purposes of signing the application form itself.

The Readability Compliance Certification was included with this form although a score of 40 or more was not obtained. We believe the form is written in simplified language, logically and clearly arranged and understandable to a person of average intelligence without special insurance knowledge. Under §31-4726(b)(2) of the District of Columbia Code, the Insurance Commissioner may permit the use of a form that scores inadequately under §31-4725(a)(1) of the Code, if the lower score more accurately reflects the readability of the form. We ask for this.

We appreciate your consideration of this matter and look forward to your acknowledgement and approval of this form. If you have any questions regarding this submission, please contact me at 410-605-2425 or via email at laurie.thurtle@carefirst.com.

Regards,

A handwritten signature in cursive script that reads "Laurie W. Thurtle".

Laurie W. Thurtle
Senior Contract Specialist
Contracting and Compliance

Cc: Daniel G. Bowerman

READABILITY COMPLIANCE CERTIFICATION

NAME & ADDRESS OF INSURER: Group Hospitalization and Medical Services, Inc. doing business
as CareFirst BlueCross BlueShield (CareFirst)
840 First Street, NE, Washington, DC 20065
202-479-8000

TITLE OF FORM: Supplement-65 Application

FORM NUMBER: SUDMVAAP (1/12)

I hereby certify that the above policy form will attach to an evidence of coverage with a Flesch reading ease score above 40.

CareFirst has reviewed the enclosed policy form and certifies that, to the best of its knowledge and belief, the form submitted is consistent and complies with the requirements of the District of Columbia Code, particularly §31-4725 and §31-4726(b)(2) of the District of Columbia Code.



Signed by Officer of the Insurer
Chester E. Burrell
President and Chief Executive Officer

1/26/2012
Date