



Regence BlueShield of Idaho is an Independent Licensee of the Blue Cross and Blue Shield Association

# Medicare Supplement Policy Change Request

Policyholder name (please print) \_\_\_\_\_

Agent Name \_\_\_\_\_ Agent Number \_\_\_\_\_

**Plan Selection (check one) - All changes are effective the first of the month following receipt of this form.**

- Plan A     
  Plan C     
  Plan F     
  Plan G     
  Senior Selection

*For further benefit information about all plans options, please see sales literature.*

1.  Yes  No Are you a resident of the state of Idaho? **If Yes:** \_\_\_\_\_ years \_\_\_\_\_ months

2.  Yes  No Do you use tobacco of any kind?

3.  Yes  No Have you been advised to have future surgery, diagnostic testing or medical treatment?

**If Yes, give details:** \_\_\_\_\_

4.  Yes  No Have you consulted with a physician or been hospitalized in the past 90 days?

**If Yes, please complete the following using extra paper if necessary:**

Patient Name	Doctor and/or Hospital	Reason Seen	Date	Recovery Complete?

5.  Yes  No Have you taken any medication or drugs within the past 12 months?

**If Yes, please complete the following using extra paper if necessary:**

Medication	Prescribing Physician	Condition Requiring Medication	Still Taking?

I certify that all statements contained herein are true to the best of my knowledge. **I understand that any misrepresentation, omission, or inaccurate information required herein shall prevent recovery under the policy if such answer is fraudulent or materially affects the risk assumed by Regence BlueShield of Idaho.** I understand this request will be underwritten to determine the extent of my eligibility, and that Regence BlueShield of Idaho will consider all medical information currently on file. I hereby expressly authorize any physician or hospital, or any other health care provider, to disclose to Regence BlueShield of Idaho any information obtained by having attended me or hereafter attending or examining me, and I understand that Regence BlueShield of Idaho will not disclose any information so obtained.

Applicant's Signature \_\_\_\_\_ Date \_\_\_\_\_

Social Security Number \_\_\_\_\_ Identification Number \_\_\_\_\_

Street Address \_\_\_\_\_ Phone Number \_\_\_\_\_

Mailing Address \_\_\_\_\_