ELIGIBILITY: COORDINATION OF BENEFITS

For coordination of benefits purposes, will any person listed on this application be covered under another health plan or contract ***at the time this policy becomes effective?*** If yes, please provide the information below. Use additional paper if necessary.

NAME OF CONTRACT HOLDER/DEPENDENT	EFFECTIVE DATE OF OTHER COVERAGE (MM/DD/YYYY) MM/DD/YYYY
NAME OF INSURANCE COMPANY	POLICY, ID, CONTRACT OR CERTIFICATE NUMBER
GROUP NUMBER	TYPE COVERAGE: ☐ INDIVIDUAL ☐ FAMILY

ELIGIBILITY: MEDICARE

Is any person to be insured enrolled in any part of Medicare (Parts A, B, C or D)? ☐ YES ☐ NO	If yes, give name of person:	MEDICARE NUMBER It may be to your advantage to enroll in a Medicare supplement or a Medicare Advantage plan. Please visit us at **bcbsalmedicare.com** to review your options.

PAYMENT & BILLING

We will accept your premium payments only if they are made from your personal **(non-business)** account. Premiums are payable in advance on a monthly basis.

PREMIUM – I agree to pay you in advance the monthly premium in the amount due before the 1st day of the coverage effective date.
Please choose either an Automatic Payment Method OR a Billing Method.
Failure to choose either an Automatic Payment Method or a Billing Method will delay the processing of your application.

PREFERRED EFFECTIVE MONTH

MONTH MM/YYYY

Please note that if your preferred effective month is not available for any reason, your contract will be effective on the next available month based on applicable guidelines.

AUTOMATIC PAYMENT METHOD

Select **ONE** payment method.

☐ **E-Check**

☐ **Debit**

☐ **Credit Card**

Please complete the included Payment Authorization Agreement and submit it along with this application. If approved, your payment will be charged monthly to your account. It may take up to 30 days to implement automatic payment. You will receive a bill for your premiums until your payment method is established. Courtesy notification will be sent to your email.

For e-check only, please mail a blank voided check to:

Blue Cross and Blue Shield of Alabama
Attention: Payment Processing Department
P.O. Box 11551
Birmingham, Alabama 35282-9722

BILLING METHOD

Select **ONE** billing method.

☐ **E-Statement**
You will receive an email notification each month when your billing statement is available. Email address is required.

☐ **Billing Statement**
You will receive a billing statement each month which includes an invoice to return with your premium payment. Courtesy notification will be sent to your email.

BINDING ARBITRATION NOTICE

THE CONTRACT YOU ARE APPLYING FOR INCLUDES FINAL AND BINDING ARBITRATION. THIS MEANS ANY DISAGREEMENT NOT SETTLED BY THE EXTERNAL REVIEW PROCESS DESCRIBED IN THE HEALTH PLAN BOOKLET WILL BE SETTLED BY ARBITRATION—NOT A COURT. THE ARBITRATOR'S DECISION IS BINDING. AN ARBITRATOR IS AN INDEPENDENT, NEUTRAL PARTY WHO MAKES A DECISION AFTER LISTENING TO BOTH PARTIES. THE DECISION OF THE ARBITRATOR CAN'T BE REVIEWED BY A COURT, EXCEPT IN CERTAIN CIRCUMSTANCES AS DESCRIBED IN THE CONTRACT. THE ARBITRATOR ACTS AS JUDGE AND JURY. BY SIGNING BELOW YOU AGREE TO SETTLE ANY DISAGREEMENT BY ARBITRATION INSTEAD OF A COURT TRIAL.

AGREEMENT TO ARBITRATE - AFTER READING THIS, I AGREE TO THE ARBITRATION PROVISIONS IN THE CONTRACT.

I acknowledge by my signature that I have read and understand the front and back of this application, that all statements made by me are true and complete, and that I agree to **binding arbitration** with respect to the health plan as described in this application and my Blue Cross and Blue Shield of Alabama health plan contract booklet.

THIS APPLICATION IS NOT COMPLETE UNLESS IT IS SIGNED AND DATED.

APPLICANT'S SIGNATURE — DATE SIGNED MM/DD/YYYY