



Medicare Supplement New Business
P.O. Box 3003, Naperville, IL 60566

Plan Change Selection (Select One)

Form with checkboxes for Plan A, Plan B, Plan C, Plan F, High Deductible Plan F, Plan G, Plan K, Plan L, and Plan N.

Applicant Information

Form for Applicant Information including fields for Name, Address, Date of Birth, Member ID Number, Residence Phone, Alternate Phone, and E-mail Address.

Acknowledgements and Signature

- 1) I hereby apply for coverage and request a policy for the Medicare Supplement plan indicated above.
2) I understand that I will be covered as of the date shown on my new Blue Cross and Blue Shield of Illinois (hereafter referred to as BCBSIL) identification card.

Signature Required

Application must be signed and dated to avoid delays in processing. I acknowledge that I have received the Outline of Coverage. If eligible for a Med-Select Plan, I have also read and understand the statements regarding Med-Select as described in the Outline of Coverage.

Applicant Signature X Date Signed: ___/___/___
(Please sign in ink.)

Questions: Call us at our customer service toll-free number 1-800-624-1723, or call your insurance agent or visit www.bcbsil.com.