



Application for Medicare Supplement Insurance Plan

HOME OFFICE USE ONLY

Instructions

- To be considered for coverage, you must have Medicare Parts A and B, reside in Illinois, and be: a) age 65 or over or b) applying within 6 months of your Medicare Part B effective date.
- If submitting a paper application, please complete in ink. Be sure to sign and date on the appropriate line(s) on pages 3 and 4. Send no money now! No payment is due until you have a chance to review your policy and make sure the coverage is right for you.

Plan Selection Check one box to apply for a Medicare Supplement Insurance plan.

<input type="checkbox"/> Plan A	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan G	<input type="checkbox"/> Plan L
<input type="checkbox"/> Plan B	<input type="checkbox"/> Standard	<input type="checkbox"/> Standard	<input type="checkbox"/> Standard
<input type="checkbox"/> Standard	<input type="checkbox"/> Medicare Select	<input type="checkbox"/> Medicare Select	<input type="checkbox"/> Medicare Select
<input type="checkbox"/> Medicare Select	<input type="checkbox"/> Plan F	<input type="checkbox"/> Plan K	<input type="checkbox"/> Plan N
<input type="checkbox"/> Plan C	<input type="checkbox"/> High Deductible	<input type="checkbox"/> Standard	<input type="checkbox"/> Standard
<input type="checkbox"/> Standard		<input type="checkbox"/> Medicare Select	<input type="checkbox"/> Medicare Select
<input type="checkbox"/> Medicare Select			
Requested Policy Effective Date			
	MONTH	DAY	YEAR

Applicant Information

Preferred Method of Contact: Mail Phone Email

Name (First)		(Middle)	(Last)	
Home Address (No P.O. Boxes)			City	State IL
Correspondence/Billing Address			City	State
Primary Phone ()	Secondary Phone ()	Age	Date of Birth Mo. / Day / Year	
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security Number - - - - -	Email address		

Payment Option (Select one payment option)

1. <input type="checkbox"/> Premium deducted from bank account: (choose one): <input type="checkbox"/> Checking <input type="checkbox"/> Savings
Account holder name: _____
Bank name: _____
Bank routing #: _____ Bank account #: _____
Account Owner Signature (if different than applicant) <input checked="" type="checkbox"/> _____
2. <input type="checkbox"/> Premium to be billed by mail
3. I will pay my premium: <input type="checkbox"/> Monthly <input type="checkbox"/> Bi-Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually

Applicant Name _____

STATEMENTS

1. You do not need more than one Medicare Supplement policy.
 2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
 3. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
 4. 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.*
 5. 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 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.
6. 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 a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB). For information on Medicaid eligibility, call your local Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

Questions?

**Call us at our Customer Service toll-free number 1-800-624-1723,
call your insurance agent at the number listed on the next page,
or visit www.bcbsil.com.**

Proxy Statement: The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Applicant Signature (optional): **X** _____

Print Your Name as You Signed It: _____ Date: ____/____/____

Applicant Name _____

Acknowledgements and Signature

1. I hereby apply for coverage and request a policy to review for the Medicare Supplement policy indicated.
2. I understand that once my first premium payment is received, I will be covered as of the date shown on the Company identification card. Once coverage begins, I understand I have 30 days to return my policy materials and receive a full refund for any premiums paid. Services are covered only when received on or after the effective date of the policy chosen, except in the case of inpatient services, where the admission must occur on or after the effective date to be covered.
3. I hereby declare that the statements and answers on this application, including but not limited to those relating to age and medical history, are true and complete to the best of my knowledge and belief. I agree that the Company, believing them to be true, shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.
4. I understand that the Company has the right to reject my application. If the Company rejects my application, I will be notified in writing. If this application is accepted, it will become part of the insurance policy.
5. I acknowledge that I have read and understand the Statements section regarding Medicare Supplement coverage. If eligible for a Medicare Select Plan, I have also read and understand the statements regarding Medicare Select as described in the Outline of Coverage. **WARNING:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information may be guilty of a felony.

SIGNATURE REQUIRED

Must be signed in ink and dated to avoid processing delays. For Power of Attorney and Legal Guardianships, be sure to submit copies of the court documents with the application.

Applicant **X** _____ **Date:** ____/____/_____

Agent Information (If Applicable)

The following statements apply if you are purchasing coverage through an agent:

- The undersigned acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if the Company accepts this application and issues an individual policy, the Company may pay the agent a commission and/or other compensation in connection with the issuance of such individual policy.
- The undersigned further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, he/she should contact the agent.
- The applicant(s) have received a copy(s) of the Medicare Supplement Buyers Guide.

Any other health insurance policies or coverages sold to the applicant which are still in force:

Any other health insurance policies or coverages sold to the applicant within the last five (5) years which are no longer in force:

I have reaffirmed that the information supplied on this application is accurate and complete.

Agent Signature: **X** _____ **Date:** ____/____/_____

Print name: **Christopher C Dee** _____ **Broker Code:** **000602554** _____

Agency name (If Applicable): _____ **Phone:** **(847) 234 -1756** _____

**Please return completed application to your agent or:
Blue Cross Blue Shield of Illinois, P.O. Box 3003, Naperville, IL 60566-7003**



Notice to Applicant Regarding
REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage coverage and replace it with a policy to be issued by Blue Cross and Blue Shield of Illinois. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, and acceptance by the replacing issuer, you find that purchase of this Medicare supplement or Medicare Advantage coverage is a wise decision, you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY BLUE CROSS AND BLUE SHIELD OF ILLINOIS:

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment: _____
- Other (please specify): _____

1. Note: If the issuer of the Medicare supplement policy applied for does not, or is otherwise prohibited from imposing preexisting condition limitations, please skip to statement 2 below. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) to the extent such time was spent (depleted) under the original policy.
3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the issuer to deny any future claims and to refund your premium as though the policy had never been in force. After the application has been completed and before you sign it, read and review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

000602554

Agent's Signature

Christopher C Dee 575 Meadowood Dr., Lake Forest, IL 60045

Agent's Number

(847) 234 -1756

Printed Name and Address of Agent

Applicant's Signature

Date



Applicant's Name _____

Name of Existing Insurer _____ Expiration Date of Existing Insurance ____ / ____ / ____

Medicare Supplement Plans: **IMPORTANT** — You **must** indicate your choice of coverage. **Mark only one box, please.**

Plan A Standard

Plan F Standard Med-Select

Plan G Standard Med-Select

Plan B Standard Med-Select

Plan F Standard (High Deductible)**

Plan N Standard Med-Select

Plan C Standard Med-Select

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
Hospital Inpatient Services	Days 1-60	All but \$1,340		<input type="checkbox"/> \$1,340 Part A Deductible* or <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$1,340 Part A Deductible
	Days 61-90	All but \$335 a day		\$335 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$670 a day		\$670 a day	\$0
	After Day 150	\$0		All Medicare-approved amounts for an additional 365 days	\$0
Skilled Nursing Home Care	Days 1-20	All costs		\$0	\$0
	Days 21-100	All but \$167.50 a day		<input type="checkbox"/> \$167.50 a day or <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$167.50 a day
	After Day 100	\$0		\$0	All costs
Medical Expenses	Physician's Services in hospital, office, or home; inpatient and outpatient medical services and supplies at a hospital; physical and speech therapy; and ambulance	80% of the Medicare-determined allowable charges after a \$183 deductible per calendar year		<input type="checkbox"/> After \$183 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, B, C, F, High F, G <input type="checkbox"/> After \$183 Medicare Part B Deductible, Plan N pays the balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. <input type="checkbox"/> \$183 Part B deductible for Plans C, F, High F <input type="checkbox"/> 100% Part B Excess Charges for Plans F, High F and G	Charges not covered by policy and Medicare <input type="checkbox"/> \$183 Part B deductible for Plans A, B, G, N <input type="checkbox"/> Part B Excess Charges for Plans A, B, C, N

This policy does comply with the minimum standards set forth in Section 363 of the Illinois Insurance Code.

Date ____ / ____ / ____ **Signature of Applicant** X

Signature of Producer X

WHITE: RETURN WITH APPLICATION • YELLOW: FOR CLIENT'S RECORDS

* Med-Select Plans require that you use Blue Cross and Blue Shield of Illinois participating Med-Select hospitals for non-emergency admissions to receive coverage for the Medicare Part A deductible.

** **High Deductible Plan F** offers the same benefits as Plan F after you have paid a \$2,240 calendar-year deductible.

Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association