



Application for Medicare Supplement Plan

P.O. Box 806162, Chicago, IL 60680-4123

You may apply for coverage if: You have Medicare Parts A and B; **AND**, You are an Illinois resident.

Plan Selection (Select One)

Plan A

Standard

Plan F

Standard Med-Select

Plan K

Standard Med-Select

Plan B

Standard Med-Select

High Deductible Plan F

Standard

Plan L

Standard Med-Select

Plan C

Standard Med-Select

Plan G

Standard Med-Select

Plan N

Standard Med-Select

Policy Effective Date

Month

Day

Year

PRODXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXX

Payment Option (Select One)

A. Financial Institution Debit Authorization – membership premium **deducted from bank account**:

Monthly Electronic Fund Transfer Account type: Checking Savings

Account holder name: _____

Bank account number: _____ Bank routing number: _____

Account Owner Signature (if different than applicant) _____

B. Membership premium **to be billed to my home address** (select one):

Every Two Months Every Six Months Once A Year

Applicant Information

First Name		Middle	Last
Mailing Address (Street or P.O. Box, City, State, ZIP+4)			
Gender Male <input type="checkbox"/> Female <input type="checkbox"/>	Date of Birth ____/____/____		Social Security Number ____-____-____
Residence Phone ()	Alternate Phone ()		E-mail Address

Medicare Claim Number

Please copy the Medicare Claim Number from your red, white and blue Medicare Card.

Part A Effective Date ____/____/____

Part B Effective Date ____/____/____

Consumer Protection Information

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 provide a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL QUESTIONS

Please answer
Yes or No

To the best of your knowledge:

- 1) Do you meet the eligibility requirements for under age 65 disability? Yes No
- 2) Did you turn age 65 in the last 6 months? Yes No
- 3) Do you have another Medicare supplement policy in force? Yes No
 - a. If yes, with what company, and what plan do you have? (Provide information below)

 - b. If yes, do you intend to replace your current Medicare supplement policy with this policy? Yes No
- 4) Are you covered for medical assistance through the state Medicaid program?
Note to Applicant: If you are participating in a "Spend-down program" and have not met your "Share of cost," please answer NO to this question Yes No
 - a. If yes, will Medicaid pay your premiums for this Medicare supplement policy? . . Yes No
 - b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No
- 5) a. 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 yes, include the effective date: ___ ___ / ___ ___ / ___ ___ ___
b. 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
c. Was this your first time in this type of Medicare plan? Yes No
d. Did you drop a Medicare supplement policy to enroll in the Medicare plan? Yes No
- 6) Do you have any other health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? Yes No
 - a. If yes, which company provides the health insurance policies or coverages that provide benefits similar to this Medicare Supplement policy? (Provide information below)

 - b. If yes, what type of policy is it? Group Individual Other (Provide information below)

Important Information Regarding Medicare Supplement Coverage

- 1) You do not need more than one Medicare Supplement policy.
- 2) Before 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) Benefits and premiums under this policy may be suspended for up to 24 months if you become entitled to benefits under Medicaid. You must request that your policy be suspended within 90 days of becoming entitled to Medicaid. If you lose (are no longer eligible for) benefits from Medicaid, this

policy can be reinstated if you request reinstatement within 90 days of the loss of such benefits and pay the required premium.

- 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 ninety (90) days of losing your employer or union-based group health plan.*
- 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 Social Security office. For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

*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.

Acknowledgements and Signature

- 1) I hereby apply for coverage and request an inspection policy for the Medicare Supplement plan indicated.
- 2) I understand that once my first premium payment is received, I will be covered as of the date shown on my Blue Cross and Blue Shield of Illinois (hereafter referred to as BCBSIL) 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, are to the best of my knowledge and belief, complete and true, and I agree that BCBSIL believing them to be true shall rely and act upon them accordingly. I hereby agree to furnish any additional information if requested.
- 4) I acknowledge that I have read and understand the Important Information Regarding Medicare Supplement section regarding Medicare Supplement coverage. If eligible for a Med-Select Plan, I have also read and understand the statements regarding Med-Select as described in the enclosed Outline of Coverage.

Signature Required

Application must be signed and dated to avoid delays in processing. I have read and understand the statements regarding Medicare Supplement coverage. I have received 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, call your insurance agent at the number listed below, or visit www.bcbsil.com.



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 C** Standard Med-Select **Plan F** Standard **Plan G** Standard Med-Select
Plan B Standard Med-Select **Plan F** Standard Med-Select (High Deductible)** **Plan N** Standard Med-Select

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but \$1,100		<input type="checkbox"/> \$1,100 Part A Deductible* or <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$1,100 Part A Deductible
	Days 61-90	All but \$275 a day		\$275 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$550 a day		\$550 a day	\$0
	Days 151 and beyond	\$0		All Medicare-approved amounts for an additional 365 days	\$0
SKILLED NURSING HOME CARE	Days 1-20 (All Plans)	All costs		\$0	\$0
	Days 21-100	All but \$137.50 a day		<input type="checkbox"/> \$137.50 a day or <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$137.50 a day
	Days 101 and beyond (All Plans)	\$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 \$155 deductible per calendar year		<input type="checkbox"/> After \$155 Medicare Part B Deductible per calendar year, 20% of Medicare-approved amounts for Plans A,B,C,F,High F,G <input type="checkbox"/> After \$155 Medicare Part B Deductible per calendar year and Plan N pays balance, other than up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense <input type="checkbox"/> \$155 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"/> \$155 Part B deductible for Plans A, B, G, N <input type="checkbox"/> Part B Excess Charges for Plans A, B, C, N
PRESCRIPTION DRUGS		Inpatient Prescription Drugs — 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant		No benefit	All costs; outpatient drugs

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

* 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 \$2,000 calendar-year deductible.

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



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 K Standard Med-Select
(Annual out-of-pocket limit of \$4,620)

Plan L Standard Med-Select
(Annual out-of-pocket limit of \$2,310)

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but \$ 1,100		<input type="checkbox"/> Plan K: \$550 Part A Deductible* <input type="checkbox"/> Plan L: \$825 Part A Deductible*	<input type="checkbox"/> Plan K: \$550 Part A deductible <input type="checkbox"/> Plan L: \$275 Part A deductible
	Days 61-90	All but \$275 a day		\$275 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$550 a day		\$550 a day	\$0
	Days 151 and beyond	\$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 \$137.50 a day		<input type="checkbox"/> Plan K: \$68.75 a day <input type="checkbox"/> Plan L: \$103.12 a day	<input type="checkbox"/> Plan K: \$68.75 a day <input type="checkbox"/> Plan L: \$34.38 a day
	Days 101 and beyond	\$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 \$155 deductible per calendar year		<input type="checkbox"/> After \$155 Medicare Calendar Year deductible, Plan K generally pays 10% and Plan L generally pays 15% of Medicare-approved amounts	Charges not covered by policy and Medicare
PRESCRIPTION DRUGS		Inpatient Prescription Drugs — 80% of allowable charges for immunosuppressive drugs during the first year following a covered transplant		No benefit	All costs; outpatient drugs

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** _____

* 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.

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

Health & Retirement Services of Illinois

(800)-739-4700

Fax (800)979-0155

SUBMITTING YOUR APPLICATION:

- Fill out the application
- Print
- Sign
- Submit (Note: if you need help enrolling, please call us 800-739-4700 and we will be glad to help you)

There are three ways to submit the application:

Submit by Mail:

Mail Application & Policy Checklist to Health & Retirement Services of Illinois
7101 N Cicero Ave Ste 202
Lincolnwood, IL 60712
Attn: Processing Department

Submit by Fax:

Fax Application & Policy Checklist to: (800)-979-0155 Attn: Administration

Submit by E-mail:

E-mail Application & Policy Checklist to pearl@healthcareil.com