BlueCross BlueShield of Illinois

Application for Medicare Supplement Insurance Plan

Instructions

HOME OFFICE USE ONLY

1. 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.
2. **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.*

☐ **Plan A**

Plan B
☐ Standard
☐ Medicare Select

Plan C
☐ Standard
☐ Medicare Select

Plan F
☐ Standard
☐ Medicare Select

☐ **Plan F High Deductible**

Plan G
☐ Standard
☐ Medicare Select

Plan K
☐ Standard
☐ Medicare Select

Plan L
☐ Standard
☐ Medicare Select

Plan N
☐ Standard
☐ 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	ZIP
Correspondence/Billing Address		City	State	ZIP
Primary Phone ( )	Secondary Phone ( )	Age	Date of Birth __ __/__ __/__ __ __ __ Mo. Day Year	
Gender Male☐ Female☐	Social Security Number ___ ___ ___ - ___ ___ - ___ ___ ___ ___	Email address		

Payment Option *(Select one payment option)*

1. ☐ Premium **deducted from bank account**: *(choose one)*: ☐ ***Checking*** ☐ ***Savings***

Account holder name:______________________________

Bank name: ______________________________

Bank routing #: ________________ Bank account #: ________________

Account Owner Signature *(if different than applicant)* **X** ________________________

2. ☐ Premium **to be billed by mail**
3. I will pay my premium: ☐ Monthly ☐ Bi-Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Applicant Name ____

Medicare Beneficiary Identifier

Please copy the Medicare Beneficiary Identifier from your red, white and blue Medicare Card. This number must be provided to us to complete your application process.

Medicare Beneficiary Identifier ☐☐☐☐☐☐☐☐☐☐☐

Part A Effective Date: ____/ 0 1 /________

Part B Effective Date: ____/ 0 1 /________

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

Please answer all questions. Please mark Yes or No below with an "X" to the best of your knowledge.

1. Did you turn age 65 in the last 6 months? Yes ☐ No ☐

2. Did you enroll in Medicare Part B in the last 6 months? Yes ☐ No ☐

If yes, what is the effective date? ___/___/_____

3. 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. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes ☐ No ☐

4. If 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), fill in your start and end dates. *(If you are still covered under this plan, leave "END" blank.)*

Start: ___/___/_____

End: ___/___/_____

a. 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 ☐

b. Was this your first time in this type of Medicare plan? Yes ☐ No ☐

c. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes ☐ No ☐

5. Do you have another Medicare Supplement or Medicare Advantage policy in force? Yes ☐ No ☐

a. If so, with what company, and what plan do you have? ________________________________

b. If so, do you intend to replace your current Medicare Supplement or Medicare Advantage policy with this policy? Yes ☐ No ☐

6. Have you had coverage under any other health insurance within the past 63 days? Yes ☐ No ☐

a. If so, with what company, and what kind of policy? *(For example, an employer, union, or individual plan)* ________________________________

b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave "END" blank.)*

Start: ___/___/_____

End: ___/___/_____

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 reinstituted 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 reinstituted 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 reinstituted 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: ______________________________ Broker Code: 000619560

Agency name *(If Applicable)*: Health & Retirement Serv. of Ill. Phone: ((800))739-4700

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

BlueCross BlueShield of Illinois

2019 Policy Checklist

000619560

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

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
Hospital Inpatient Services	Days 1-60	All but $1,364		☐ $1,364 Part A Deductible* **or** ☐ $0 Plan A Only	☐ $0 **or** ☐ $1,364 Part A Deductible
	Days 61-90	All but $341 a day		$341 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $682 a day		$682 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 $170.50 a day		☐ $170.50 a day **or** ☐ $0 Plans A, B	☐ $0 **or** ☐ $170.50 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 changes after a $185 deductible per calendar year		☐ After $185 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, B, C, F, High F, G ☐ After $185 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. ☐ $185 Part B deductible for Plans C, F, High F ☐ 100% Part B Excess Charges for Plans F, High F and G	Charges not covered by policy and Medicare ☐ $185 Part B deductible for Plans A, B, G, N ☐ 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 $2,300 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

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BlueCross BlueShield of Illinois

2019 Policy Checklist

000619560

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 $5,560)

Plan L ☐ Standard ☐ Med-Select
(out-of-pocket limit of $2,780)

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
Hospital Inpatient Services	Days 1-60	All but $1,364		☐ Plan K: $682 Part A Deductible* ☐ Plan L: $1,023 Part A Deductible*	☐ Plan K: $682 Part A deductible ☐ Plan L: $341 Part A deductible
	Days 61-90	All but $341 a day		$341 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $682 a day		$682 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 $170.50 a day		☐ Plan K: $85.25 a day ☐ Plan L: $127.88 a day	☐ Plan K: $85.25 a day ☐ Plan L: $42.62 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 changes after a $185 deductible per calendar year		☐ After $185 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