BlueCross BlueShield of Illinois

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

Application for Medicare Supplement Plan

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

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) X _____

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 ☐ Female ☐	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

To the best of your knowledge:

Please answer Yes or No

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 reinstituted 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 reinstituted 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.

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.

Primary Applicant's Signature (optional) X _____

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

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 the purposes of purchasing the insurance, and that if BCBSIL accepts this application and issues an Individual Policy, BCBSIL may pay the agent a commission and/or other compensation in connection with the issuance of such Individual Policy.
- The undersigned acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by BCBSIL in connection with the issuance of the Individual Policy, he/she should contact the agent.
- The applicant has received a copy of the Medicare Supplement Buyers Guide.

Applicant's Initials _____

List the following: 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:

If the applicant is applying for one of the Med-Select contracting Plans, I affirm that I have fully explained to the applicant the requirements of using a Blue Cross and Blue Shield of Illinois contracting Med-Select hospital in order to receive coverage for the Medicare Part A deductible. I have also reaffirmed that the information supplied on this application is accurate and complete.

_____ __ __/__ __/__ __ __ __
Agent Signature — Date Signed

_____ _____
Print Name of Agent — Agent Code: (SSN or Tax ID Number)

_____ _____ (____)_____
Firm's Name (If Applicable) — Agent E-mail Address — Phone Number