Application for Medicare Supplement Plan

For coverage to go into effect, you must be age 65 or over, live in Illinois, and have Medicare Parts A and B. **Send no money now!** No payment is due until you approve your coverage.

A. Plan Selection

I would like to apply for: ***(check only one box)***

Plan A Medicare Supplement	Plan C Medicare Supplement	Plan D Medicare Supplement	Plan E Medicare Supplement	Plan F Medicare Supplement	High Deductible Plan F Medicare Supplement
☐ Standard (CB-45.1)	☐ Standard (CB-45.3)	☐ Standard (CB-45.4)	☐ Standard (CB-45.5)	☐ Standard (CB-45.6)	☐ Standard (CB-45.7)
	☐ Med-Select (CB-46.1)	☐ Med-Select (CB-46.2)	☐ Med-Select (CB-46.3)	☐ Med-Select (CB-46.4)	

Make policy effective: ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

Payment Option *(Reminder: Please do not send any money now)*

I would like to pay my premiums: (check only one box) ☐ Every Two Months ☐ Every Six Months ☐ Once A Year

I understand I may apply to pay my premium monthly by bank draft after I make my first premium payment.

B. Personal Information

Name ______________________
Last *First* *M.I.*

Address ______________________

City ______________ County ______________

State ______________ ZIP ______________

☐ Male ☐ Female

Your Birthdate ☐☐ ☐☐ ☐☐☐☐
MONTH DAY YEAR

Your Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐

C. Medicare Claim Number

Please see your Medicare card for this information.

Copy the Medicare Claim Number from your red, white and blue Medicare card. This number must be provided for us to complete your application process.

Your Medicare Claim No. ☐☐☐ - ☐☐ - ☐☐☐☐☐
(PLEASE INCLUDE ANY PREFIXES OR SUFFIXES)

D. Consumer Protection Information

Please answer all questions to the best of your knowledge.

1. **Do you have any other Medicare Supplement insurance policy or certificate in force?**........................ ☐ **Yes** ☐ **No**
   a. If yes, with which company?
   ____
   b. If yes, do you intend to replace your current Medicare Supplement policy with this policy? .... ☐ **Yes** ☐ **No**
   If yes, you must complete the replacement form.
2. **Do you have any other health insurance policies or coverage that provides benefits similar to this Medicare Supplement policy?**............................ ☐ **Yes** ☐ **No**
   If yes, see reverse side.
3. ***Medicaid* is a public aid program for people with low income. It is not the same as Medicare. Are you covered by *Medicaid*?** .... ☐ **Yes** ☐ **No**
   If yes, see reverse side.

Signature

Must be signed and dated to avoid delays in processing.

I have read and understand the statements on the reverse side regarding Medicare Supplement coverage. I have received an Outline of Coverage for the policy I applied for, and a Medicare Supplement Buyers Guide. If choosing Med-Select, I have also read and understand the statements regarding Med-Select as described in the enclosed Outline of Coverage.

PLEASE SIGN HERE IN INK
X ______________________
SIGNATURE OF APPLICANT

DATE SIGNED
/ /
MONTH DAY YEAR

Phone Number ☐☐☐ - ☐☐☐ - ☐☐☐☐
AREA CODE

Note to Agent: Please complete information on reverse side →

Blue Cross and Blue Shield of Illinois, P.O. Box 806162, Chicago, Illinois 60680-4123

Complete ONLY if you answered "yes" to question #2 in the CONSUMER PROTECTION INFORMATION section on the reverse side:

a. Which company provides the health insurance policies or coverage that provides benefits similar to this Medicare Supplement policy?

b. What type of policy is it?

Complete ONLY if you answered "yes" to question #3 in the CONSUMER PROTECTION INFORMATION section on the reverse side: If covered by *Medicaid*, do you qualify for:

a. ☐ Specified Low Income Medicare Beneficiary assistance (SLMB)

b. ☐ Qualified Medicare Beneficiary assistance (QMB), or

c. ☐ Other *Medicaid* medical benefits?

Important Information Regarding Medicare Supplement Coverage

You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. The benefits and premiums under your Medicare Supplement policy will be suspended 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 policy will be reinstituted if requested within 90 days of losing Medicaid eligibility. Counseling services are 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 1-800-252-8635.
For questions on Medicare Supplement insurance, call 1-800-MEDICARE (1-800-633-4227).

Please sign the signature line on the reverse side.

I hereby apply for membership and request an inspection policy for the Medicare Supplement policy indicated. I understand that once my first premium payment is received, I will be covered as of the date shown on my Blue Cross 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.

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 the Company believing them to be true shall rely and act upon them accordingly. I hereby agree to furnish any additional information, if requested.

Agent Information — 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 Plans, I affirm that I have fully explained to the applicant the requirements of using a Blue Cross and Blue Shield of Illinois participating 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.

X
(Signature of Agent)

Date Signed: / /
Month Day Year

(Print Name of Agent)

Agent Code:
(Social Security Number or Tax ID Number)

Firm's Name:
(If Applicable)

Phone Number: ( )
Area Code

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

CONSUMER MARKETS

®Registered Service Marks of the Blue Cross and Blue Shield Association, An Association of Independent Blue Cross and Blue Shield Plans

Policy Checklist

Applicant's Name ____________________

Policy Number ____________________

Name of Existing Insurer ____________________

Expiration Date of Existing Insurance _______ / _______ / _______

CONSUMER MARKETS

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 D ☐ Standard ☐ Med-Select

Plan E ☐ Standard ☐ Med-Select

Plan F ☐ Standard ☐ Med-Select

Plan F (High Deductible) ☐ Standard

High Deductible Plan F offers the same benefits as Plan F after you have paid a $1,730 calendar-year deductible.

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but $912		☐ $912 Part A Deductible* **or** ☐ $0	☐ $912 Part A Deductible **or** ☐ $0*
	Days 61-90	All but $228 a day		$228 a day	$0
	Days 91-150 (Lifetime Reserve)	All but $456 a day		$456 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	
	Days 21-100	All but $114.00 a day		☐ $114.00 a day **or** ☐ $0	☐ $114.00 a day **or** ☐ $0
	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 $110 deductible per calendar year		For charges covered under Part B Medicare: ☐ After $110 Medicare Calendar Year deductible, 20% of Medicare allowable charges ☐ Part B Deductible ☐ 100% Part B Excess Charges	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

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