



**BlueCross BlueShield  
of Illinois**

# Application for Medicare Supplement Insurance Plan

## Instructions

HOME OFFICE USE ONLY

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

## Applicant Information

Preferred Method of Contact:     Mail     Phone     Email

Name (First)		(Middle)	(Last)		
Home Address (No P.O. Boxes)			City	State <b>IL</b>	Zip
Correspondence/Billing Address			City	State	Zip
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"/> <b>Checking</b> <input type="checkbox"/> <b>Savings</b>  Account holder name: _____  Bank name: _____  Bank routing #: _____ Bank account #: _____  Account Owner Signature (if different than applicant) <b>X</b> _____
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](http://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 Services of Illinois 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**



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
<b>Hospital Inpatient Services</b>	Days 1-60	All but \$1,316		<input type="checkbox"/> \$1,316 Part A Deductible* <b>or</b> <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 <b>or</b> <input type="checkbox"/> \$1,316 Part A Deductible
	Days 61-90	All but \$329 a day		\$329 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$658 a day		\$658 a day	\$0
	Days 151 and beyond	\$0		All Medicare-approved amounts for an additional 365 days	\$0
<b>Skilled Nursing Home Care</b>	Days 1-20 (All Plans)	All costs		\$0	\$0
	Days 21-100	All but \$164.50 a day		<input type="checkbox"/> \$164.50 a day <b>or</b> <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 <b>or</b> <input type="checkbox"/> \$164.50 a day
	Days 101 and beyond (All Plans)	\$0		\$0	All costs
<b>Medical Expenses</b>	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 per calendar year, 20% of Medicare-approved amounts for Plans A, B, C, F, High F, G <input type="checkbox"/> After \$183 Medicare Part B Deductible per calendar year Plan N pays the 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	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
				<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	
<b>Prescription Drugs</b>		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 \$2,200 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 \$5,120)*
**Plan L**  Standard  Med-Select

*(out-of-pocket limit of \$2,560)*

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
<b>Hospital Inpatient Services</b>	Days 1-60	All but \$1,316		<input type="checkbox"/> Plan K: \$658 Part A Deductible* <input type="checkbox"/> Plan L: \$987 Part A Deductible*	<input type="checkbox"/> Plan K: \$658 Part A deductible <input type="checkbox"/> Plan L: \$329 Part A deductible
	Days 61-90	All but \$329 a day		\$329 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$658 a day		\$658 a day	\$0
	Days 151 and beyond	\$0		All Medicare-approved amounts for an additional 365 days	\$0
<b>Skilled Nursing Home Care</b>	Days 1-20	All costs		\$0	\$0
	Days 21-100	All but \$164.50 a day		<input type="checkbox"/> Plan K: \$82.25 a day <input type="checkbox"/> Plan L: \$123.38 a day	<input type="checkbox"/> Plan K: \$82.25 a day <input type="checkbox"/> Plan L: \$41.12 a day
	Days 101 and beyond	\$0		\$0	All costs
<b>Medical Expenses</b>	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 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
<b>Prescription Drugs</b>		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.

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

# Health & Retirement Services of Illinois

**(800)-739-4700**

**Fax (800)979-0155**

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## 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 [premer@healthcareil.com](mailto:premer@healthcareil.com)