



Empty box for Home Office Use Only

Application for Medicare Supplement Insurance Plan

Instructions

- 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 7 and 8. 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 section with checkboxes for Plan A, Plan F, Plan G, Plan G Plus, Plan N, and Plan N Plus. Includes a field for Requested Policy Effective Date and a note about availability for Plans F and High Deductible F.

Applicant Information section with fields for Name (First, Middle, Last), Home Address, Correspondence/Billing Address, Primary/Secondary Phone, Age, Date of Birth, Gender, Social Security Number, and Email Address. Includes a field for Preferred Method of Contact (Mail, Phone, Email).

Tobacco Use section with a definition of tobacco user and a checkbox question: 'Within the past 6 months, have you used tobacco 4 or more times per week on average, excluding religious or ceremonial uses?' with Yes/No options.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Blue Medicare Supplement | c/o Member Services | PO Box 3388 | Scranton, PA 18505

Applicant Name: _____

Premium Discounts

A BCBSIL Medicare Supplement premium discount may be available. Eligibility criteria are described below. If you are eligible for a discount, the discount will be applied to your next bill and remain in effect as long as you are enrolled in your BCBSIL Medicare Supplement plan. Discounts cannot be combined; only one type of discount per member is permitted.

Household Discount

You may be eligible for a discount if you reside with a spouse or civil union/domestic partner or have resided with as many as three adults age 60 or older for the last 12 months. Applies to BCBSIL Medicare Supplement policies issued with an effective date on or after May 1, 2019. The discount is 10%.

Are you applying for this discount?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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Continue with BlueSM Discount

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2022 and you were enrolled in a Blue Cross and Blue Shield commercial group or individual health insurance coverage plan and that coverage was within one year of your BCBSIL Medicare Supplement policy becoming effective. The discount is 7%.

Are you applying for this discount?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, provide your previous commercial group or individual coverage subscriber ID:

Blue Family DiscountSM

You may be eligible for a discount if you enrolled in a BCBSIL Medicare Supplement policy issued with an effective date on or after April 1, 2024 and you meet the criteria for both the Household Discount AND the Continue with Blue Discount. The discount is 12%.

Are you applying for this discount?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If yes, provide your previous commercial group or individual coverage subscriber ID:

Applicant Name: _____

Payment Option (Select one payment option)

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

Account holder name:

Bank name:

Bank routing number: Bank account number:

Account Owner Signature (if different than applicant)

Bank Draft Authorization Agreement
By signing this application, I request and authorize BCBSIL and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the financial institution named below to accept and honor the same to my account.
I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium or provide reimbursement for any part of the premium now or in the future.
I also understand that both the financial institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advanced notice to BCBSIL by telephone prior to a scheduled withdrawal date. I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

2. Premium **to be billed by mail**

3. I will pay my premium: **Monthly** **Quarterly** **Semi-Annually** **Annually**

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: / Part B Effective Date: /

Applicant Name: _____

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 Insurance 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Did you enroll in Medicare Part B in the last 6 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes , what is the effective date?	Effective Date:	
3. Are you covered for medical assistance through the state Medicaid program? NOTE TO APPLICANT: <i>If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.</i>	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. If yes , will Medicaid pay your premiums for this Medicare Supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. If yes , do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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. <i>(If you are still covered under this plan, leave "End Date" blank.)</i>	Start Date:	End Date:
a. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b. Was this your first time in this type of Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c. Did you drop a Medicare Advantage policy to enroll in the Medicare plan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

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Applicant Name: _____

Consumer Protection Information		
5. Do you have another Medicare Supplement policy in force?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 policy with this policy?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Have you had coverage under any other health insurance within the past 63 days?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
a. If so , with what company, and what kind of policy? <i>(For example, an employer, union, or individual plan)</i> _____		
b. What are your dates of coverage under the other policy? <i>(If you are still covered under the other policy, leave "End Date" blank.)</i>	Start Date:	End Date:

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.*
 6. Counseling services may be available in your state to provide advice concerning your purchase of a Medicare Supplement Insurance Plan 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 Plans, call 1-800-MEDICARE (1-800-633-4227).
 7. Under Illinois Senate Bill 147, if you are between the ages of 65 and 75 and have enrolled in a Medicare Supplement policy, you are entitled to an annual open enrollment period lasting 45 days starting with your birthday. During this time, you will be able to purchase a BCBSIL Medicare Supplement policy that offers benefits equal to or lesser than those provided by your previous coverage. This policy cannot be denied or conditioned, nor discriminate in the pricing of coverage because of health status, claims experience, receipt of health care, or a medical condition of the individual. Purchasing a new Medicare Supplement policy will require reapplying within the 45 day window.
- * 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.

Questions?

Call us at our Customer Service toll-free number **877-384-9297**,
call your insurance agent at the number listed on page 9, or visit **www.bcbsil.com**.

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Applicant Name: _____

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): _____

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.
- 6. I acknowledge that any agent is acting on my 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.
- 7. I acknowledge if I desire additional information regarding any commissions or other compensation paid to the agent by the Company in connection with the issuance of the individual policy, I should contact the agent.
- 8. I acknowledge that I have received a copy of the Medicare Supplement Buyer's Guide.
- 9. **Outline of Coverage:** I acknowledge receipt of Outline of Coverage.

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: _____	Date: / /
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Applicant Name: _____

Agent Information (If Applicable)

The following information is to be filled out by an agent, if Applicant is purchasing coverage through an agent.

Please list any other health insurance policies or coverages sold to the applicant which are still in force:

Please list 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:

Date: / /

Print Name:

Broker Code:

Agency Name (If Applicable):

Agent Phone:

Please return the completed application to your agent or:

Blue Medicare SupplementSM
c/o Member Services
PO Box 3388
Scranton, PA 18505

Medicare Supplement insurance plans are offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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



Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____ Expiration Date of Existing Insurance ____ / ____ / ____

Service	Benefit	Medicare Pays	Existing Coverage Pays	Supplement Covers	You Pay
Hospital Inpatient Services	Days 1-60	All but \$1,632		<input type="checkbox"/> \$1,632 Part A Deductible* or <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$1,632 Part A Deductible
	Days 61-90	All but \$408 a day		\$408 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$816 a day		\$816 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 \$204 a day		<input type="checkbox"/> \$204 a day or <input type="checkbox"/> \$0 Plan A only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$204 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 charges after a \$240 deductible per calendar year		<input type="checkbox"/> After \$240 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, F, High F, G, G Plus and High G <input type="checkbox"/> After \$240 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. <input type="checkbox"/> \$240 Part B deductible for Plans F and High F <input type="checkbox"/> 100% Part B Excess Charges for Plans F, High F, G, G Plus and High G	Charges not covered by policy and Medicare <input type="checkbox"/> \$240 Part B deductible for Plans A, G, G Plus, High G and N <input type="checkbox"/> Part B Excess Charges for Plans A and 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

Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Medicare Supplement plans provided by Blue Cross and Blue Shield of Illinois, which refers to Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), and refers to HCSC Insurance Services Company (HISC). HCSC and HISC are independent licensees of the Blue Cross and Blue Shield Association.



Notice to Applicant Regarding REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

Save this notice! It may be important to you in the future

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage coverage and replace it with a policy to be issued by Blue Cross and Blue Shield of Illinois. Your new policy will provide 30 days within which you may decide, without cost, whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Blue Cross and Blue Shield of Illinois:

I have reviewed your current medical or health coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment: _____
- Other (please specify): _____

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

AGENT'S SIGNATURE

PRINTED NAME OF APPLICANT

PRINTED NAME OF AGENT

APPLICANT'S SIGNATURE

AGENT'S WRITING ID NUMBER

DATE

Not connected with or endorsed by the U.S. Government or Federal Medicare Program.

Medicare Supplement Insurance Plans have eligibility requirements, exclusions and limitations. For costs and complete details (including outlines of coverage), call a licensed insurance agent at the toll-free number shown.

Medicare Supplement insurance plans are offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

HMO, HMO-POS and PPO plans provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). HMO plan provided by Illinois Blue Cross Blue Shield Insurance Company (ILBCBSIC). HCSC and ILBCBSIC are Independent Licensees of the Blue Cross and Blue Shield Association. HCSC and ILBCBSIC are Medicare Advantage organizations with a Medicare contract. Enrollment in HCSC's and ILBCBSIC's plans depends on contract renewal.