

Thank you for choosing...



Enrolling is Simple. Just Follow These 3 Easy Steps...

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact your agent at: (630) 930-9364.

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), bi-monthly (every two months) or bi-annually (every six months).

Step 3

Complete the Policy Checklist – If you currently have a Medicare Supplement policy with another company, include this information on the Policy Checklist. If you do not have an existing supplement policy, leave this information blank.

Step 4

FAX THE COMPLETED APPLICATION TO:

Fax: (847) 220-9280

We will be in contact with you upon receipt of your completed application. Do Not Cancel your current coverage until a new policy is approved and you have received written confirmation of the policy's rates and benefits from the insurance company.



FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

FAX#: (847) 220-9280

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

- Please contact me at this phone number after you have reviewed my application for completeness and accuracy _____.
- Please contact me at this email after you have reviewed my application for completeness and accuracy _____.



P.O. Box 806162, Chicago, IL 60680-4123

You may apply for coverage if: [X] You have Medicare Parts A and B; AND, [X] You are an Illinois resident.

Plan Selection (Select One)

Plan A, Plan B, Plan C, Plan F, High Deductible Plan F, Plan G, Plan K, Plan L, Plan N. Includes checkboxes for Standard and Med-Select options.

Policy Effective Date: [] [] / [] [] / [] [] [] []
Month Day Year

Payment Option (Select One)

A. Financial Institution Debit Authorization - membership premium deducted from bank account. B. Membership premium to be billed to my home address (select one):

Applicant Information

Form with fields for First Name, Middle, Last, Mailing Address, Gender, 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.

Claim number input boxes: [] [] [] - [] [] - [] [] [] [] [] []

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

Please answer
Yes or No

To the best of your knowledge:

- 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 reinstated 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 reinstated 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 undersigned confirms that he/she 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
Ryan Kennelly	601678
Print Name of Agent	Agent Code: (SSN or Tax ID Number)
Firm's Name (If Applicable)	() Phone Number
ryan@ilhealthagents.com	Agent E-mail Address



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

SERVICE	BENEFIT	MEDICARE PAYS	EXISTING COVERAGE PAYS	SUPPLEMENT COVERS	YOU PAY
HOSPITAL INPATIENT SERVICES	Days 1-60	All but \$1,100		<input type="checkbox"/> \$1,100 Part A Deductible* or <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$1,100 Part A Deductible
	Days 61-90	All but \$275 a day		\$275 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$550 a day		\$550 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 Plans)	All costs		\$0	\$0
	Days 21-100	All but \$137.50 a day		<input type="checkbox"/> \$137.50 a day or <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$137.50 a day
	Days 101 and beyond (All Plans)	\$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 \$155 deductible per calendar year		<input type="checkbox"/> After \$155 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 \$155 Medicare Part B Deductible per calendar year and Plan N pays 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 <input type="checkbox"/> \$155 Part B deductible for Plans C, F, High F <input type="checkbox"/> 100% Part B Excess Charges for Plans F, High F and G	Charges not covered by policy and Medicare <input type="checkbox"/> \$155 Part B deductible for Plans A, B, G, N <input type="checkbox"/> Part B Excess Charges for Plans A, B, C, N
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.

****High Deductible Plan F** offers the same benefits as Plan F after you have paid a \$2,000 calendar-year deductible.

WHITE: RETURN WITH APPLICATION • YELLOW: FOR CLIENT'S RECORDS