

Application Instructions for BlueCross BlueShield of Illinois Medicare Supplement Plan

1. Have your Medicare card and Social Security card available to fill in the required information below.
2. Print all pages of the application, including policy checklist.
3. Complete all questions and sections of the application. Complete the fax cover letter below and fax to (847) 220-9280 for review along with the completed application and policy checklist.
4. **SEND NO MONEY NOW!** No payment is due until you have a chance to review your policy.

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.

Illinois Health Agents will review your application for completeness and accuracy before they submit it to BlueCross BlueShield of Illinois for processing.

Please contact us if you have any questions regarding the application or the application process. You can reach us at (630) 930-9364.

2010 Policy Checklist

Applicant's Name _____

Policy Number _____

Name of Existing Insurer _____

Expiration Date of Existing Insurance _____ / _____ / _____



BlueCross BlueShield of Illinois

Experience. Wellness. Everywhere.™

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 B Standard Med-Select

Plan F (High Deductible) Standard

Plan C Standard Med-Select

Plan D Standard Med-Select

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

Plan E 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	<input type="checkbox"/> \$1,100 Part A Deductible or <input type="checkbox"/> \$0*
	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 costs		\$0	
	Days 21-100	All but \$137.50 a day		<input type="checkbox"/> \$137.50 a day or <input type="checkbox"/> \$0	<input type="checkbox"/> \$137.50 a day or <input type="checkbox"/> \$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 \$155 deductible per calendar year		For charges covered under Part B Medicare: <input type="checkbox"/> After \$155 Medicare Calendar Year deductible, 20% of Medicare allowable charges <input type="checkbox"/> Part B Deductible <input type="checkbox"/> 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.**



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 D, Plan E, Plan F, High Deductible Plan F, Plan K, Plan L. Each plan has 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: [] 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

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.
[] [] [] - [] [] - [] [] [] [] [] []

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

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

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

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