BlueCross BlueShield of Illinois

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 4 and 5.** 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.

- ☐ **Plan A**
- **Plan B**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan C**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan F**
  - ☐ Standard
  - ☐ Medicare Select
- ☐ **High Deductible Plan F**
- **Plan G**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan K**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan L**
  - ☐ Standard
  - ☐ Medicare Select
- **Plan N**
  - ☐ Standard
  - ☐ Medicare Select

Requested Policy Effective Date: ____/____/____

Applicant Information

Name (First)	(Middle)	(Last)	
Home Address (No P.O. Boxes)	City	State **IL**	ZIP
Correspondence/Billing Address	City	State	ZIP
Primary Phone	Secondary Phone	Age	Date of Birth / /
Gender ☐ Male ☐ Female	Social Security Number	Email Address	
Preferred Method of Contact: ☐ Mail ☐ Phone ☐ Email			

Tobacco Use

Blue Cross and Blue Shield of Illinois (BCBSIL) defines a tobacco user as a person who is using or has used any tobacco products in the last 6 months prior to the date of enrollment for a plan. This includes but is not limited to cigarettes, cigars, smokeless tobacco products, electronic cigarettes, dissolvable tobacco products, and vaping.

Within the past 6 months, have you used tobacco 4 or more times per week on average, excluding religious or ceremonial uses?	☐ Yes	☐ No

Applicant Name: _____

Household Discount

You may be eligible for a household discount if at least two members reside in the same household and are enrolled in a BCBSIL Medicare Supplement Insurance Plan effective on or after May 1, 2019.

Are you eligible for the household discount?	☐ Yes	☐ No

If <u>yes</u>, provide a qualifying household member's information (optional):

Name (First)	(Last)	Policy Number

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?	☐ Yes	☐ No
2. Did you enroll in Medicare Part B in the last 6 months?	☐ Yes	☐ 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:** *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. If yes, do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?	☐ Yes	☐ 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. *(If you are still covered under this plan, leave "End Date" blank.)*	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?	☐ Yes	☐ No
b. Was this your first time in this type of Medicare plan?	☐ Yes	☐ No
c. Did you drop a Medicare Advantage policy to enroll in the Medicare plan?	☐ Yes	☐ No
5. Do you have another Medicare Supplement policy in force?	☐ Yes	☐ 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?	☐ Yes	☐ No
6. Have you had coverage under any other health insurance within the past 63 days?	☐ Yes	☐ No
a. If so, with what company, and what kind of policy? *(For example, an employer, union, or individual plan)* _____		
b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave "End Date" blank.)*	Start Date:	End Date:

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 reinstituted 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 reinstituted 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).

* If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted 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 the next page,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.

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: / /

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:

Applicant Name: _____

Please return the completed application to your agent or:

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