



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
Hospital Inpatient Services	Days 1-60	All but \$1,340		<input type="checkbox"/> \$1,340 Part A Deductible* or <input type="checkbox"/> \$0 Plan A Only	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$1,340 Part A Deductible
	Days 61-90	All but \$335 a day		\$335 a day	\$0
	Days 91-150 (Lifetime Reserve)	All but \$670 a day		\$670 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 \$167.50 a day		<input type="checkbox"/> \$167.50 a day or <input type="checkbox"/> \$0 Plans A, B	<input type="checkbox"/> \$0 or <input type="checkbox"/> \$167.50 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 \$183 deductible per calendar year		<input type="checkbox"/> After \$183 Medicare Part B Deductible, 20% of Medicare-approved amounts for Plans A, B, C, F, High F, G <input type="checkbox"/> After \$183 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"/> \$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	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

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

* 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 \$2,240 calendar-year deductible.

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

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