BlueCross BlueShield of Illinois

Medicare Supplement New Business
P.O. Box 3003, Naperville, IL 60566

Application for Medicare Supplement Plan Changes

Plan Change Selection (Select **One**)

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

Applicant Information

First Name	Middle	Last	
Mailing Address (Street or P.O. Box)	City	State	ZIP+4
Date of Birth ___ ___/___ ___/___ ___ ___ ___	Member ID Number	Residence Phone ( )	
Alternate Phone ( )	E-mail Address		

Acknowledgements and Signature

1) I hereby apply for coverage and request a policy for the Medicare Supplement plan indicated above.
2) I understand that I will be covered as of the date shown on my new Blue Cross and Blue Shield of Illinois (hereafter referred to as BCBSIL) identification card. I understand I have 30 days to review my policy materials. If I am not satisfied, I will be allowed to switch back to my original Medicare Supplement plan.

Signature Required

Application must be signed and dated to avoid delays in processing. I acknowledge that I have received the Outline of Coverage. If eligible for a Med-Select Plan, I have also read and understand the statements regarding Med-Select as described in 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, or call your insurance agent or visit www.bcbsil.com.

Agent

Name	Address	Phone