

PBT MediCap Medicare Supplement Plans APPLICATION FORM

Complete this application if you or your spouse is over age 65 or if medically disabled.

Sponsored by the Illinois State Medical Society (ISMS), the Chicago Medical Society (CMS), and the Illinois State Dental Society (ISDS)



Underwritten by: Physicians' Benefits Trust Life Insurance Company
PBT Insurance Office
200 E. Randolph Street, 5th Floor
Chicago, IL 60601

Medicare Supplement Plans Application Instructions

- Please complete all the sections of this form.
- Please print in all CAPITAL LETTERS.
- Please return your completed application in the envelope provided.
- If return envelope is lost or misplaced, please mail to:

Physicians' Benefits Trust Life Insurance Company
200 E. Randolph Street, 5th Floor
Chicago, IL 60601

If you have any questions:
ISMS and CMS members call: 1-800-621-0748
ISDS members call: 1-800-898-0926



I PERSONAL INFORMATION

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____) _____ Email (optional) _____

Birth Date ____/____/____ SSN# ____-____-____
Month Day Year

Medicare ID# (found on your Medicare card): _____

Medicare Part A Effective Date (found on your Medicare card): _____

Medicare Part B Effective Date (found on your Medicare card): _____

Membership Affiliation: CMS ISMS ISDS

II SELECT THE PLAN THAT BEST FITS YOUR NEEDS

Check the Plan you wish to apply for: Plan A Plan F

Monthly rate (please refer to the rate chart): \$ _____

Check how you would like to be billed: Quarterly Semi-Annually

III ELIGIBILITY

You are eligible if you are a member of ISMS, CMS or ISDS and enrolled in Medicare Parts A and B, and not duplicating Medicare Supplement coverage. (If you are not yet age 65, you are eligible only if you enrolled in Medicare Part B within the last 6 months, unless you are an “Eligible Person” entitled to guaranteed acceptance. (Please review your Guide To Physicians’ Benefit Trust Medicare Supplement Portfolio of Plans.)

Payment: Please refer to the Rate Chart for the monthly cost of the plan you have selected. Send no money now. **PBT will bill you after your coverage is issued.**

Effective Date: Your coverage will become effective on the first day of the month following receipt and approval of your completed application. You will receive a Certificate of Insurance confirming your effective date. (If you would like your coverage to begin at a later date, please indicate below).

My Requested Effective Date (first of the month only): ____/____/____
Month Day Year

IV YOUR ACCEPTANCE MAY BE GUARANTEED

Please circle Yes or No to the following questions.

- 1) Did you turn age 65 in the last 6 months? YES NO
- 2) Did you enroll in Medicare Part B within the last 6 months? YES NO

STOP: If you answered “YES” to either of the first two questions, your ACCEPTANCE IS GUARANTEED. Please proceed to **Section V** and review the information provided. Be sure to sign and date where requested. If you did NOT answer “YES” to the first two questions, proceed to Question 3.

3) Have you lost other health insurance coverage and, if so, are you an eligible person as defined within the termination notice you received from your prior insurer? YES NO

If you answered “NO” to any of the three questions above, your acceptance is not guaranteed and you may be declined for coverage based upon your health history. Please complete a Health History Questionnaire and submit it along with this application.
You also need to answer the following questions (please circle your response):

- Are you covered for medical assistance through the state Medicaid program? (Medicaid is a state-run healthcare program that helps with medical costs for people with low or limited income. It is not the federal Medicare program.) YES NO
- Will Medicaid pay your premiums for this Medicare Supplement policy? YES NO
- Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? YES NO
- 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 below. If you are still covered under this plan, leave “END” blank.
START: _____ END: _____
- 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
- Was this your first time in this type of Medicare plan? YES NO
- Did you drop a Medicare Supplement policy to enroll in the Medicare plan? YES NO
- Do you have another Medicare Supplement policy in force? YES NO
- If “yes,” do you intend to replace your current Medicare Supplement policy with this policy? YES NO

After providing your answers, please proceed to Section V and review the information provided. Be sure to sign and date where requested.

If you answered “YES” to Question 3, answer the following questions (please circle your response):

- Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) YES NO
- If “yes,” with what insurance company and what kind of policy (an employer, union, or individual plan)?

- What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave “END” blank.)
START: _____ END: _____
- Are you replacing the health insurance indicated in the second bullet? YES NO

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 include a copy of the notice from your prior insurer with your applications.

After providing your answers, proceed to Section V and review the information provided. Be sure to sign and date where requested.

V FOR YOUR PROTECTION – PLEASE READ AND SIGN WHERE INDICATED.

- You do not need more than one Medicare Supplement policy. You may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy.
- 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 reinstated if requested within 90 days of losing Medicaid eligibility. 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.
- 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 90 days of losing your employer-or union-based group health plan. 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.
- 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).

X _____
Your Signature (REQUIRED)

Date

VI IMPORTANT AUTHORIZATION AND INFORMATION

Please read carefully, and sign and date where indicated.

- My signature below indicates that I have read and understand the contents of this application.
- I declare that the answers on this application are complete and true to the best of my knowledge and belief and are the basis for issuing coverage. I understand that the application becomes a part of the insurance contract and that if the answers are incomplete, incorrect, or untrue, Physicians' Benefits Trust, may have the right to rescind my coverage, adjust my premium, or reduce my benefits.
- Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties.
- I understand that the coverage under the plan for which I am applying will not take effect until issued by Physicians' Benefits Trust.

PLEASE CONTINUE ON NEXT PAGE



Authorization for the Release of Medical Information

To: Any licensed physician, medical practitioner, hospital, pharmacy, clinic, or like facility; insurance company; or other organization, institution or person. I authorize you to give Physicians' Benefits Trust any data or records you may have about me or my mental or physical health. Physicians' Benefits Trust needs this data to find out if I qualify for health insurance and to administer my coverage, if accepted. For purposes of determining my qualification for coverage, this authorization is valid for the term of the coverage.

Please see the enclosed materials to determine if the following pre-existing condition waiting period applies to you:

Subject to creditable coverage. Creditable coverage is health insurance coverage you had before you enrolled in your new health plan, as long as it was not interrupted by a period of 63 or more days. The amount of time you had "credible" health insurance coverage can be used to offset a pre-existing condition exclusion period in your new health plan.

If you had at least a full year of health coverage at your previous job and you enrolled in your new health plan without a break of 63 days or more, your new health plan cannot subject you to the pre-existing condition exclusion.

I understand that the plan will not pay benefits for stays beginning or medical expenses incurred during the first 6 months of coverage if they are due to conditions for which medical advice was given or treatment recommended by or received from a physician within 6 months prior to the insurance effective date. *Note: If you are signing as the legal representative for the applicant, please enclose a copy of the appropriate legal documentation.*

X _____
Your Signature (REQUIRED)

Today's Date (REQUIRED)

Questions?

ISMS and CMS members call: 1-800-621-0748
ISDS members call: 1-800-898-0926

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200 E. Randolph Street, 5th Floor
Chicago, IL 60601

Administered by: Affinity Insurance Services, Inc.