

APPLICATION FORM

Only for Members and Spouses turning 65

Physicians' Benefits Trust MediCap Medicare Supplement Plans

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

Instructions

- Complete all the sections of this form.
- Please print in all CAPITAL LETTERS.
- Circle must be darkened with Black or Blue INK, as shown below.

EXAMPLE:

Gender M F

- 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

QUESTIONS? ISMS and CMS members call Toll-Free 1-800-621-0748.
ISDS members call: 1-800-898-0926 to talk to a Customer Service Representative.



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YOUR ACCEPTANCE MAY BE GUARANTEED

- a) Did you turn age 65 in the last 6 months? Yes No
- b) Did you enroll in Medicare Part B within the last 6 months? Yes No

If you answered "YES" to either of the questions above, your ACCEPTANCE IS GUARANTEED and you can SKIP TO NUMBER 5.

- c) 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 questions above, GO TO NUMBER 4.

If you answered 'YES' to question c), GO TO NUMBER 4 AND COMPLETE 4a) through 4d)

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FOR YOUR PROTECTION, YOU ARE REQUIRED TO ANSWER ALL OF THE FOLLOWING QUESTIONS 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).

1a) 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

1b) Will Medicaid pay your premiums for this Medicare Supplement policy?..... Yes No

1c) Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? Yes No

2a) 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:** _____

2b) 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

2c) Was this your first time in this type of Medicare plan? Yes No

2d) Did you drop a Medicare Supplement policy to enroll in the Medicare plan? Yes No

3a) Do you have another Medicare Supplement policy in force? Yes No

3b) If "yes," do you intend to replace your current Medicare Supplement policy with this policy? Yes No

4a) Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual plan) Yes No

4b) If "yes," with what company and what kind of policy? _____

4c) What are your dates of coverage under the other policy? (If you are still covered under the other policy, leave "END" blank.)

START: _____ **END:** _____

4d) Are you replacing the other health insurance indicated in question 4a? Yes No

X _____

YOUR SIGNATURE (REQUIRED)

PLEASE CONTINUE ON NEXT PAGE 

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IMPORTANT AUTHORIZATION AND VERIFICATION 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, Affinity Insurance Services 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.

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.

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?

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