ENROLLMENT APPLICATION/CHANGE FORM

Group # | Section # | Social Security #

Account # | Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Changes**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☐ **Yes, Event Date:** ____ / ____ / ____

Event: ☐ New Hire ☐ Marriage* ☐ Birth
☐ Adoption, Placement for Adoption or Suit for Adoption (provide legal documents)
☐ Court Order (provide court order or decree)
☐ Loss of Other Coverage
☐ Other (explain): ________________

Effective Date of Benefits: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental
☐ Term Life ☐ Dependent Life
☐ Short-Term Disability ☐ Long-Term Disability

List names of those canceling in Section 4 below

Event: ☐ Divorce** ☐ Death
☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security – –

Mailing Address - Street - Apt #	City	State	ZIP code

Email Address	☐ Male ☐ Female	Home/Cell Phone #

Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	On average, how many hours a week do you work? (required)

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement: ________ ☐ COBRA Coverage Start Date ________ Projected End Date ________

☐ Illinois Continuation (insured plans only) Start Date ________ Projected End Date ________

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (1-50 Employees)

Affordable Care Act Plans
☐ PPO ☐ Other ________
☐ Blue Choice Preferred PPO℠
☐ Blue Options℠
☐ Blue Precision HMO℠
☐ BlueCare Direct℠
Plan # (required) ________

Grandfathered and Grandmothered/Transitional Plans
☐ Blue Advantage Entrepreneur PPO℠
☐ Blue Choice Select PPO℠
☐ BlueEdge Select HSA℠
☐ BlueEdge HSA℠
☐ BlueEdge HCA Direct℠
☐ PPO Value Choice
☐ Blue Advantage HMO℠
☐ Blue Advantage HMO Value Choice℠
☐ Community Participation Organization (CPO)
☐ CPO Value Choice
☐ Other ________
Plan # (required) ________

Mid-Market and Large Group Standard Plans (51+ Employees)

Mid-Market & Large Group Standard Plans 51+
☐ PPO
☐ Blue Advantage HMO℠
☐ Blue Advantage HMO Value Choice℠
☐ Blue Choice Options℠
☐ Blue Choice Select PPO℠
☐ BlueEdge HSA℠
☐ BlueEdge Select HSA℠
☐ Plan # (required) ________
☐ Other ________

Previous BCBSIL or HMO Membership
Group #: ________
Section #: ________
Identification #: ________

Large Group Custom Plans (151+ Employees)

☐ Traditional
☐ PPO
☐ CPO
☐ CPO Value Choice
☐ HMO Illinois®
☐ HMO Illinois® w/HCA
☐ Blue Advantage HMO℠
☐ Blue Advantage HMO℠ w/HCA
☐ Blue Choice Options℠
☐ Blue Choice Select PPO℠
☐ BlueEdge HCA℠
☐ BlueEdge HSA℠
☐ BlueEdge HCA Direct℠
☐ BlueEdge Select HCA℠
☐ BlueEdge Select HSA℠
☐ BlueEdge Select HCA Direct℠
☐ Vision
☐ Hearing
☐ Medicare Supplement
☐ Other ________

Dental

☐ BlueCare Dental PPO℠
☐ BlueCare Dental HMO℠
☐ Dental Group # (if different than Medical Group policy #)
____

☐ Employee and Party to a Civil Union or Domestic Partner
Gender: ☐ Male ☐ Female

☐ Individual/Employee
☐ Employee/Children
☐ Employee/Spouse
☐ Family

Primary Language: ________

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance

☐ I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: ________ Wage Rate $________ per ☐ hour ☐ week ☐ month ☐ year

Group Basic Term Life and AD&D ☐ I do not apply ☐ I do apply Amount $________

Group Dependents' Life ☐ I do not apply ☐ I do apply

Group Supplemental Life ☐ I do not apply ☐ I do apply

Employee Election: $ ________ Spouse Election: $ ________ Child Election: $ ________

Short-Term Disability ☐ I do not apply ☐ I do apply

Long-Term Disability ☐ I do not apply ☐ I do apply

	First Name	Initial	Last Name	Relationship	Birth Date (MM/DD/YYYY)	Social Security #
Primary Beneficiary						– –
Contingent Beneficiary						– –

As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.
* The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).
** The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).
*** The term "spouse" includes a legal spouse and party to a civil union or domestic partnership (coverage subject to your employer's plan).

Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Last Name: | Social Security #: — — | Group #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY
(If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application.)

Employee/Enrollee's Name		PCP Name PCP #	IPA Name IPA #
WPHCP Name WPHCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #

Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner ☐ Party to a Civil Union		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
IPA Name IPA #		WPHCP Name WPHCP #	HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code		

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

If disabled child is over the dependent age limit of your employer's plan, please attach a completed Disabled Dependent Certification and the Disabled Dependent Physician Certification document.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE ALL AREAS THAT APPLY

Complete this section only if you or any of your dependents have other health and/or dental coverage **that will not be canceled** when the coverage under this application becomes effective. **List names of each individual covered**:

Group Coverage ☐ Y ☐ N	Individual Coverage ☐ Y ☐ N	Name and Address of Other Insurance Carrier	Effective Date (MM/DD/YYYY)	Type of Policy ☐ Employee Only ☐ Employee/Spouse ☐ Employee/Child(ren) ☐ Family

Name of Policyholder	Birth Date (MM/DD/YYYY)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: ____ End Date: ____ Medicare B (Medical) Effective Date: ____ End Date: ____ Medicare D (Drug) Effective Date: ____ End Date: ____ Medicare D (Drug) Carrier: ____	Medicare HIC # (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

Name of person covered:	Medicare A (Hospital) Effective Date: ____ End Date: ____ Medicare B (Medical) Effective Date: ____ End Date: ____ Medicare D (Drug) Effective Date: ____ End Date: ____ Medicare D (Drug) Carrier: ____	Medicare HIC # (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

BlueCross BlueShield of Illinois

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for declining **Health**: ☐ Other Group Health Coverage – Carrier: ______ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage – Carrier: ______ ☐ Other (explain) ______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Employee	Reason for declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other (explain)______ ☐ I am not enrolled in any dental insurance plan, but do not want this coverage
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Illinois or Dearborn Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Applicant's Signature ______________________ Date ______________

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

Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone: 855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD: 855-661-6965
35th Floor	Fax: 855-661-6960
Chicago, Illinois 60601	Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019	Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html