BLUE CROSS BLUE SHIELD APPLICATION AND POLICY CHANGE FORM REQUIRED DOCUMENTS FOR NEW EMPLOYEES
OR CURRENT EMPLOYEES MAKING CHANGES

INSURANCE COSTS JANUARY 01, 2019 THROUGH DECEMBER 31, 2019

SINGLE COVERAGE - **$30.52 PER MONTH** *EMPLOYEE ONLY*
$14.09 PER PAY FOR EMPLOYEES ON 26 PAYS
$18.31 PER PAY FOR EMPLOYEES ON 20 PAYS

FAMILY COVERAGE - **$93.34 PER MONTH** *EMPLOYEE + 1 OR MORE* **$65.60 PER MONTH**
$43.08 PER PAY FOR EMPLOYEES ON 26 PAYS, OPTIONAL DENTAL $30.28
$56.00 PER PAY FOR EMPLOYEES ON 20 PAYS, OPTIONAL DENTAL $39.36

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1. ***Employees electing single coverage***

   No documentation is required

   PLEASE NOTE: Employees will be given insurance coverage upon submission of their insurance form. Dependents will be added upon receipt of required documents.

2. ***Spouse*** - To verify the eligibility of your legal spouse, you **must** submit a COPY of:

   Legal Marriage Certificate

   AND

   Your Most Recent Federal Tax Return. Send the first two pages of your most recent 1040 federal income tax return, showing filing status as well as your and your spouse's signatures and the filing date. If you file separately, please send the first two pages of your's and your spouse's most recent 1040 federal income tax return.
   Please **black out any personal financial information** such as income and account numbers. Do not send any tax return schedules OR W-2's.
   E-filers can send in their printed e-filed copy indicating it was filed electronically with a PIN, or the Form 8453 *U.S. Individual Income Tax Transmittal for an IRS e-file Return*, along with the tax return if a PIN was not used (in lieu of signatures).

   OR

   Legal Separation OR Divorce Decree. If dropping spouse from your plan, a copy of the Legal Separation or Divorce Decree showing such date **must** be provided.

3. ***Civil Union Partner*** – To verify the eligibility of your civil union partner, you **must** submit a COPY of..

   Civil Union Certificate

   AND

   Supporting Financial Documentation. You must provide evidence of a current, mutual financial obligation shared between the employee and civil union partner. Examples:

   Your most recent joint Illinois state income tax return,

   OR

   TWO of the following documents: current mortgage statement, current lease, current property tax assessment for real property, auto loan, homeowners/renters or auto insurance policy, brokerage or investment account. Please **black out any personal financial information** such as income and account numbers.

4. Biological Child (under age 19) – To verify the eligibility of a biological child, you **must** submit a COPY of:

Birth Certificate or **birth registration card**

OR

For children 6 months of age or younger: Documentation on hospital letterhead indicating the birth date of the child or children under 6 months, as well as the parents' names.

5. Biological Child (age 19 to 26th birthday) – To verify the eligibility of a biological child from age 19 to their 26th birthday, you **must** submit a COPY of:

Birth Certificate or **birth registration card**

6. Adopted Child Documents – To verify the eligibility of an adopted child or a child placed with you for adoption, you **must** submit a COPY of the following documents. The documents you submit will depend on the current stage of the adoption:

Official **court/agency placement papers** for a child placed with you for adoption (initial stage)

OR

Official Court **Adoption Agreement** for Adopted Child (mid-stage)

OR

Birth Certificate (final stage)

7. Stepchild Documents – To verify the eligibility of your stepchild, you **must** submit a COPY of:

Child's **Birth Certificate** or **birth registration card** showing the child's parent is the employee's spouse.

AND

Marriage Certificate showing legal marriage between the employee and the child's parent.

AND

Your **Most Recent Federal Tax Return**. Send the first two pages of your most recent 1040 federal income tax return, showing filing status as well as your and your spouse's signatures and the filing date. If you file separately, please send the first two pages of your spouse's most recent 1040 federal income tax return as well. Please **black out any personal financial information**, such as income and account numbers. Do not send any tax return schedules OR W-2's. E-filers can send in their printed e-filed copy indicating it was filed electronically with a PIN, or the Form 8453 *U.S. Individual Income Tax Transmittal for an IRS e-file Return*, along with the tax return if a PIN was not used (in lieu of signatures).

8. Other Child Documents (Grandchild, Niece/Nephew, Brother/Sister, Other) – To verify the eligibility of a grandchild, niece/nephew, brother/sister, or any other type of child for whom you are the legal guardian, you **must** submit a COPY of:

Court papers demonstrating legal guardianship, including the person or persons named as the legal guardian.

9. Child of Civil Union Partner Documents – To verify the eligibility of a child of your civil union partner, you **must** submit a COPY of:

Child's **Birth Certificate** or **birth registration card** showing the child's parent in the employee's civil Union partner.

AND

Civil Union Certificate showing a civil union between the employee and the child's parent.

AND

Supporting Financial Documentation. You must provide evidence of a current, mutual financial Obligation shared between the employee and civil union partner. Examples:

Your most recent joint Illinois state income tax return,

OR

TWO of the following documents: current mortgage statement, current lease, current property tax assessment for real property, auto loan, homeowners/renters or auto insurance policy, brokerage or investment account. Please **black out any personal financial information** such as income and account numbers.

10. Court-Ordered Medical Coverage – If you do not have custody of a child, but you do have a written court order that requires your employer to provide medical coverage for this child, you **must** submit a COPY of:

Qualified Medical Child Support Order (QMCSO)

OR

National Medical Support Notice (NMSN)

OR

Divorce Decree

11. Disabled Child, 26 Years and Older – To verify the continuing eligibility of your disabled child over the age of 26, you **must** submit a COPY of:

Physician's current determination letter. Please submit the most recent, current physician's determination letter OR Social Security Disability determination letter. Letters must be dated within the past 18 months.

BlueCross BlueShield of Illinois

Dearborn National®*
Underwritten by Fort Dearborn Life Insurance Company®

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① ENROLLEE: **New Enrollment:** ☐ Timely ☐ Special ☐ Late | **Open Enrollment:** ☐ New Member ☐ Plan Change ☐ Add Dependents

② EFFECTIVE DATE: ___/___/___ | **Group Number:** P41595 | **Section Number:** | **Identification Number:**

③ COBRA / Illinois Continuation Section | **Employee Status:** ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___

☐ **COBRA:** Start Date ___/___/___ Projected End Date ___/___/___ | ☐ **IL Continuation Privilege:** Start Date ___/___/___ Projected End Date ___/___/___

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.) ☐ 3. Dependent (reach age limit, other.)
☐ 2. Spouse (divorce from employee, death of employee, other.) ☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ COVERAGE APPLIED FOR: Check all that apply.**

Medical

☐ Traditional
☐ HMO Illinois
☐ w/HCA (BlueEdge HMO)
☐ BlueAdvantage HMO
☐ w/HCA (BlueEdge HMO)
☐ BlueEdge HSA
☒ PPO
☐ BlueEdge HCA
☐ Blue*Choice* Select
☐ BlueEdge Select HSA
☐ BlueEdge Select HCA
☐ BlueEdge Direct HCA
☐ BlueEdge Select Direct HCA
☐ BlueDecision PPO
☐ PPO Value Choice
☐ CPO
☐ CPO Value Choice
☐ Vision
☐ Hearing
☐ Medicare Supplement

Dental

☐ Individual / Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Enter Dental Group number if different than Medical Group policy number.

☐ Dental Group #: _____
☐ BlueCare Dental PPO
☐ BlueCare Dental HMO (Select your dental office in section 6 and 7 when applicable)

Dearborn National Group #: _____

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____
Identification #: _____

⑤ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

CHANGES

Date: / /

☐ HMO Medical Group/IPA
☐ PCP and/or WPHCP
☐ Name
☐ Address
☐ Telephone
☐ Reinstate
☐ From PPO to HMO
☐ From HMO to PPO
☐ From HMOI to BA HMO
☐ From BA HMO to HMOI
☐ Medicare Coverage
☐ FDL Beneficiary

ADD DEPENDENTS

Date: / /

☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: _____

CANCEL DEPENDENTS

Date: / /

☐ Divorce
☐ Age Limit
☐ Other: _____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section ⑦.

CANCEL
(Check all that apply)

Date: / /

☐ Terminate Coverage
☐ Waive Coverage**
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other: _____

*After checking the appropriate physician change, circle reason:

☐ PCP
☐ WPHCP

A. Availability
B. PCP moved office
C. Location
D. PCP added to Network
E. Dissatisfied with PCP
F. PCP office/facility undesirable
G. Staff
H. Other _____

**If not electing coverage, please read, complete and sign Section ⑪.

⑥ EMPLOYEE INFORMATION:

Company Name: Joliet Public Schools District 86

Start Here

Last Name: | First Name: | Mid. Initial | E-Mail Address: | Cell Phone Number

Street Address: | Apt. No.: | City: | State: | Zip:

Date of Birth: ____/____/____ Are You Eligible for Family Coverage: ☐ No ☐ Yes Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: ___ — ___ — ___ Employee Identification Number (if known): _____

Telephone No.: Bus.: ( ) _____ Home: ( ) _____ Date of Hire: ___/___/___

Dept. No.: _____ Payroll Location: _____ Employee Clock No.: _____

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____

PCP #: _____ PCP Name: _____ WPHCP Medical Group/IPA#: _____

WPHCP Medical Group Name: _____ WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____

If CPO/CPO Value Choice: Network # CO: _____ **If BlueCare Dental HMO: Office ID#:** _____

Employment Status: ☐ **Actively at Work** ☐ **Retired** **If retired, retirement date:** _____ ☐ **COBRA/IL Continuation**

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Are you covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below must be completed:**

HIC #: _____
MEDICARE A: Start Date: ___/___/___ End Date: ___/___/___
MEDICARE B: Start Date: ___/___/___ End Date: ___/___/___
ESRD DIALYSIS: Start Date: ___/___/___ End Date: ___/___/___
DISABILITY: Start Date: ___/___/___ End Date: ___/___/___

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦Ⓐ SPOUSE/DOMESTIC PARTNER:

Date of Birth: ____/____/____ Last Name (Only If Different): _____

First Name: _____ Social Security Number: ___ — ___ — ___

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____ WPHCP Medical Group/IPA #: _____

PCP #: _____ PCP Name: _____ WPHCP Medical Group Name: _____

WPHCP (Physician) #: _____ WPHCP (Physician) Name: _____ **If BlueCare Dental HMO: Office ID#:** _____

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below must be completed:**

HIC #: _____
MEDICARE A: Start Date: ___/___/___ End Date: ___/___/___
MEDICARE B: Start Date: ___/___/___ End Date: ___/___/___
ESRD DIALYSIS: Start Date: ___/___/___ End Date: ___/___/___
DISABILITY: Start Date: ___/___/___ End Date: ___/___/___

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* Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

EMPLOYEE AND DEPENDENT INFORMATION: Company Name: Joliet Public Schools Group #: P41595

* Employee Last Name: Employee First Name: Mid. Initial

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

* ⑦ Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): Social Security Number: _____—_____—_____ If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medical Group/IPA Name: PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name:_____WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: _____WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name*: _____

If BlueCare Dental HMO: Office ID#:_____

* Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

☐ SON ☐ DAUGHTER Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): Social Security Number: _____—_____—_____ If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medical Group/IPA Name: PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name:_____WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: _____WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name*: _____

If BlueCare Dental HMO: Office ID#:_____

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

☐ SON ☐ DAUGHTER Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ ☐ ELIGIBLE MILITARY PERSONNEL

Address (if different from Employee's address): Social Security Number: _____—_____—_____ If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Medical Group/IPA Name: PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name:_____WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: _____WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name*: _____

If BlueCare Dental HMO: Office ID#:_____

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes If Yes, the section below must be completed:

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

⑧ OTHER INSURANCE INFORMATION:

* If you or any of your family members have OTHER GROUP COVERAGE, Check all that apply. ☐ Health: Policy #: _____ ☐ Dental: Policy #: _____

☐ Prescription Drug Coverage: Policy #: _____ ☐ Vision: Policy #: _____ ☐ Hearing: Policy #: _____

If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage

EMPLOYED BY: _____ Insured's Name: _____ Date of Birth: ____/____/____

Insurance Company Name: _____ Address: _____

City: _____ State: _____ Zip: _____ Telephone Number: _____

⑨ DEARBORN NATIONAL:

Employee Job Title: _____ Class Type: _____

Basic Salary: $ _____ ☐ Hourly ☐ Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually

Check Coverage Applied For: Term Life/AD&D: ☐ No ☐ Yes $ _____ Dependent Life: ☐ No ☐ Yes $ _____ Weekly Income: ☐ No ☐ Yes $ _____

Supplemental Life: ☐ No ☐ Yes $ _____ Long Term Disability: ☐ No ☐ Yes $ _____ ☐ Voluntary AD&D: $ _____ ☐ Single ☐ Family

Permanent Life Insurance: ☐ No ☐ Yes $ _____ If Yes: ☐ Automatic Premium Loan or ☐ Replaces An Existing Policy

* BENEFICIARY: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated.

Last Name: _____ First Name: _____ Relationship: _____

⑩ I APPLY FOR COVERAGE AS INDICATED ABOVE, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Dearborn National (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

* Date Signed: ____/____/____ Signature of Applicant: _____

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ Myself ☐ My spouse ☐ My spouse and dependents ☐ My dependents ☐ Myself, my spouse and my dependents

Reason: ☐ Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧) ☐ Covered under a Medicare supplement plan

☐ Other (please explain)_____

Date Signed: ____/____/____ **Signature of Applicant:** _____

*A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.