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

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INSURANCE COSTS JANUARY 01, 2021 THROUGH DECEMBER 31, 2021

SINGLE COVERAGE - **$34.70 PER MONTH** *EMPLOYEE ONLY*
$16.02 PER PAY FOR EMPLOYEES ON 26 PAYS
$20.82 PER PAY FOR EMPLOYEES ON 20 PAYS

FAMILY COVERAGE - **$106.13 PER MONTH** *EMPLOYEE + 1 OR MORE* **$64.86 PER MONTH**
$48.98 PER PAY FOR EMPLOYEES ON 26 PAYS, OPTIONAL DENTAL $29.93
$63.68 PER PAY FOR EMPLOYEES ON 20 PAYS, OPTIONAL DENTAL $38.91

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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/Certified 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*

## ENROLLMENT APPLICATION AND POLICY CHANGE

# DIRECTIONS FOR COMPLETING APPLICATION FORM

Please read the directions thoroughly and detach them before completing this form. Use black or blue ballpoint pen only. Print neatly. Do not abbreviate.

Complete all fields answering each question as accurately as possible. **If you are unsure or have questions about any of the information requested on this form, please ask for guidance from your employer.**

① **ENROLLEE:** Check the reason you are completing this form.

**Timely Enrollment:** Your first opportunity to enroll after becoming eligible.

**Special Enrollment:** You are enrolling within 31 days of a special enrollment event as specified in the Federal HIPAA regulations (e.g., birth, adoption or placement for adoption, marriage, divorce** or involuntary loss of other coverage).

**Membership Change:** Any change to your current membership such as adding dependents, canceling dependents or changing your benefits. This change may occur outside of open enrollment.

**Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership.

② **EFFECTIVE DATE OF BENEFITS:** Enter requested effective date and your group, section and identification numbers. THIS WILL BE YOUR FIRST DATE OF EMPLOYMENT OR IF COBRA, YOUR FIRST DATE COBRA BEGINS

**COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period.

③ **EMPLOYEE/FORMER EMPLOYEE STATUS:** Check the appropriate box to indicate whether you are an Active, COBRA, IL Continuation or Retiree employee.

④ **COBRA/IL Continuation:** If you are a COBRA/IL Continuation enrollee, enter the requested start and end date for your COBRA/IL Continuation benefits. The remaining COBRA/IL Continuation information will be completed by Blue Cross and Blue Shield of Illinois (BCBSIL).

⑤ **COVERAGE APPLIED FOR:** Check all coverages that you are enrolling for based on the plans offered by your employer. If you previously had BCBSIL coverage, enter the prior group, section and identification numbers at the bottom of this section. If you are enrolling for Family Coverage, be sure to include information on family members in Section ⑧. **If you are declining coverage, read, complete and sign Sections** ⑥ and ⑫. If you are unsure of your group size or whether your plan is Standard or Custom, please ask for guidance from your employer.

⑥ **CHANGES TO EXISTING MEMBERSHIP:** Check all boxes that apply to change coverage, add or cancel dependents, or cancel coverage. If you are changing your primary care physician (PCP) or Woman's Principal Health Care Provider (WPHCP), circle the reason(s) why at the bottom of this section.

**NOTE: Usually Medical Group/Individual Practice Association (IPA) changes are not allowed if a member or dependent is receiving in-hospital care or is in the third trimester of pregnancy.**

To **add a dependent,** check the appropriate box. Members may add dependents within 31 days of a qualifying event (e.g., marriage, birth and/or adoption of a child or during open enrollment). Enter the date of the qualifying event. NOTE: List only those dependents to be added in Section ⑧. If coverage is changing from Individual to Family, check the appropriate box in Section ⑥. See your employer for other requirements to add dependents.

To **cancel a dependent,** check the appropriate box. Enter the date the dependent is to be canceled from coverage. NOTE: List only those dependents to be canceled in Section ⑧. If coverage is changing from Family to Individual, check the appropriate box in Section ⑦.

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** The term "divorce" in Section 1 includes legal divorce and the comparable termination of a civil union or domestic partnership.

BlueCross BlueShield of Illinois

Dearborn National

⑦ **EMPLOYEE INFORMATION: Answer every question that applies to you.**
If changing name and/or address, check the appropriate box in Section ⑥ and enter your **Name** and **Address** in section ⑦. Be sure that you have completed Section ②.

Enter your social security and identification numbers.

- Include your employee identification number if you know it.
- Your social security number is used for internal administrative purposes and for other purposes required or permitted by applicable law.

If you selected **HMO** coverage in Section ⑤, you must select a Medical Group or IPA and PCP for **each person to be covered.** You must also select a PCP within the selected Medical Group/IPA for **each person to be covered.** You may choose a different Medical Group/IPA for each person. Care received from a WPHCP may be eligible for coverage without referrals from your PCP. However, your PCP and your WPHCP must be affiliated with or employed by your Participating IPA/Medical Group in order for each person to be eligible for coverage. Until we receive your selected Medical Group/IPA, you may not be eligible and your claims may be denied. Be sure to enter the Medical Group/IPA number, name, PCP number and name.

If you selected **CPO** or **CPO Value Choice**, you must select a CPO Network.

If you selected **Dental HMO**, include your Dental HMO group number and select a Dental HMO office for **each person to be covered.**

If you are covered by **Medicare**, enter your HIC number, which is the Medicare ID number on your Medicare ID card. Enter the start and end dates where they apply for: Medicare A, Medicare B, End Stage Renal Disease (ESRD), and Disability. The ESRD start date is the day ESRD regular course at dialysis begins, (or the date of kidney transplant in the case of total renal failure). The disability start date is the date the beneficiary is entitled to Medicare due to disability.

⑧ **FAMILY COVERAGE INFORMATION:** Answer every question as it applies to your family. If you are changing existing membership, list only those dependents to be added or canceled.

A) **SPOUSE, DOMESTIC PARTNER, PARTY TO A CIVIL UNION —** Enter complete information (gender, date of birth, name, including last name if different). If you selected HMO coverage in Section ⑤, or your spouse, domestic partner, or party to a civil union is covered by Medicare, complete the HMO and Medicare sections as instructed in Section ⑦. NOTE: In some situations, your employer may not offer coverage for spouses, domestic partners and parties to a civil union. Please contact your employer for more information.

B) **CHILDREN —** Enter complete information for your child(ren). If you selected HMO coverage in Section ⑤, or your dependent(s) is covered by Medicare, complete the HMO and Medicare sections as instructed in Section ⑦. Space for additional dependents is provided on the second page of this application. If necessary, use a separate piece of paper and attach it to this application.

If your employer offers coverage for children and your children are eligible, your children are eligible for health and/or dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26 (check with your employer for additional details regarding eligibility requirements). In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law. If you elect HMO or Blue Choice Select℠ coverage, your dependents must live or work within the defined service area.

⑨ **OTHER INSURANCE INFORMATION:** If you have other insurance coverage, enter the information requested **completely**. This information will allow for the proper coordination of your health care benefits.

⑩ **DEARBORN NATIONAL:** If you are enrolling with Dearborn National, enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply. If necessary, use a separate piece of paper and attach it to this application.

⑪ **SIGNATURE LINE FOR NEW/CHANGING COVERAGE:** Please read, date and sign this Section. **Your signature and the date are required.**

⑫ **WAIVER OF COVERAGE:** BCBSIL's policy requires that you (the employee) enroll in order to also enroll your dependents. If you choose to waive any coverage, your dependents cannot enroll in that coverage. However, you can enroll yourself in coverage and choose to waive it for any of your dependents.

Use this section to indicate if you do not wish to enroll yourself and/or any of your dependents in the following types of coverage: Medical, Dental, Vision, Basic Life, Dependent Life, Short-Term Disability (offered only to employees), Long-Term Disability (offered only to employees) and Voluntary Life (offered only to employees). NOTE: This coverage waiver does not apply to any COBRA Continuation rights you might have.

BlueCross BlueShield of Illinois

Dearborn National*

# ENROLLMENT APPLICATION AND POLICY CHANGE

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

**② EFFECTIVE DATE OF BENEFITS:** ___/___/____ Group #: P41595 Section #: EMPLOLYER Identification #: EMPLOYER
☐ Completion of Other Eligibility Requirements

**③ EMPLOYEE/FORMER EMPLOYEE STATUS**
☑ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date ___/___/____

**④ COBRA / ILLINOIS CONTINUATION**

☐ 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)
☐ 2. Spouse (divorce** from employee, death of employee, other)
☐ 3. Dependent (reach age limit, other)
☐ 4. Spouse and Dependents (divorce** from employee, death of employee, other)

**⑤ COVERAGE APPLIED FOR: Check all that apply (add one Medical, Dental, Life, if applicable).**
After checking coverage applied for or making changes to existing membership, complete Plan #, Group #, Section #, Name and Social Security #.

**Small Group 1-50 Affordable Care Act Plans**
☐ PPO
☐ Blue Choice Preferred PPO℠
☐ Blue Options℠
☐ Blue Precision HMO℠
☐ BlueCare Direct℠
☐ Plan #: _____

**Small Group 1-50 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
☐ Plan #: _____

**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 #: _____

**Large Group Custom Plans 151+**
☐ Traditional
☑ PPO ONLY OPTION OF PLAN IS THE PPO
☐ CPO
☐ CPO Value Choice
☐ HMO Illinois®
☐ w/HCA
☐ 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

**Dental** ONLY OPTION OF PLAN IS THE PPO
☑ BlueCare Dental PPO℠
☐ BlueCare Dental HMO℠
☐ Individual / Employee
☐ Employee & Spouse
☐ Employee & Child(ren)
☐ Family
☐ Employee & Party to a Civil Union or Domestic Partner
Gender: ☐ Male ☐ Female

MUST SELECT I/E OR FAMILY

Enter Dental Group # if different than Medical Group policy #.
Dental Group #: SAME #P41595

**Life** INCLUDED WITH BENEFIT PACKAGE FOR EMPLOYEE ONLY
Dearborn National Group #: F011290-0001

**Previous BCBSIL or HMO Membership**
Group #: _____
Section #: _____
Identification #: _____

**⑥ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.**

**CHANGES**
Date ___/___/____
☐ HMO Medical Group/IPA†
☐ PCP and/or WPHCP†
☐ Name ☐ Address
☐ Telephone ☐ Reinstate
☐ From PPO to HMO
☐ From HMO to PPO
☐ From HMO Illinois to Blue Advantage HMO
☐ From Blue Advantage HMO to HMO Illinois
☐ Medicare Coverage
☐ FDL Beneficiary
☐ Other: _____

**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 ⑧.**

**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 ⑫.

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** The term "divorce" in Section 4 includes legal divorce and the comparable termination of a civil union or domestic partnership.

COMPLETE ALL AREAS BETWEEN ARROWS

⑦ **EMPLOYEE INFORMATION:** Company Name: JOLIET PUBLIC SCHOOLS DISTRICT 86 Group #: P41595

Employee Last Name: Employee First Name: Mid. Initial

Email Address: Cell Phone #:

Street Address: Apt. #:

City: State: ZIP code:

Date of Birth: ___/___/____ Are You Eligible for Family Coverage: ☐ No ☐ Yes

Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Party to a Civil Union or Domestic Partner ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security #: _____ — _____ — _____

Employee Identification # (if known): N/A

Telephone #: Business: ( _____ ) _____ Home: ( _____ ) _____ Date of Hire: ___/___/____

Dept. #: N/A Payroll Location: BUILDING: Employee Clock #: N/A

**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 #: _____ If BlueCare Dental HMO, Office ID #: _____

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

Are you covered or applying for coverage under your employer's health care plan, and are you 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 **FAMILY COVERAGE INFORMATION:** List all eligible dependents.

⑧Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union

Gender: ☐ Male ☐ Female

Last Name (only if different): _____ Date of Birth: ___/___/___

First Name: _____ Social Security #: _____ — _____ — _____

**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 #: _____

Are you covered or applying for coverage under your employer's health care plan, and are you 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 FAMILY AND DEPENDENT COVERAGE INFORMATION:**

List all eligible dependents: *If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form. 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.*

⑧Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different): _____ First Name: _____

☐ ELIGIBLE MILITARY PERSONNEL ☐ DISABLED DEPENDENT

Address (if different from employee's address): _____

Social Security #: _____ — _____ — _____ **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 #: _____

Are you covered or applying for coverage under your employer's health care plan, and are you 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: ___/___/____ |

COMPLETE THIS HIGHLIGHTED QUESTION FOR EACH DEPENDENT

☐ SON ☐ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different): _____ First Name: _____

☐ ELIGIBLE MILITARY PERSONNEL ☐ DISABLED DEPENDENT

Address (if different from employee's address): _____

Social Security #: _____ — _____ — _____ **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 #: _____

Are you covered or applying for coverage under your employer's health care plan, and are you 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 ☐ DISABLED DEPENDENT

Address (if different from employee's address): _____

Social Security #: _____ — _____ — _____ **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 #: _____

Are you covered or applying for coverage under your employer's health care plan, and are you 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: ___/___/____ |

## ⑨ 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 code: _____ Telephone #: _____

## ⑩ DEARBORN NATIONAL:

*The group Term Life & AD&D, STD and LTD products are underwritten by Dearborn National® Life Insurance Company.*

Employee Job Title: _____ Class Type: _ _____

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

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

Weekly Income: ☐ No ☐ Yes $ _____ Supplemental Life: ☐ No ☐ Yes $ XXXXXXXXX

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.

DO NOT LIST YOURSELF

Last Name: _____ First Name: _____

Relationship: _____

## ⑪ 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: _____

## ⑫ If you are declining enrollment

for yourself and/or eligible dependents (children, spouse, party to a civil union or domestic partner) 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 in:

ONLY SIGN SECTION 12 IF YOU ARE DECLINING ENROLLMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| | **Medical for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| | **Dental for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| | **Vision for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| " | **Basic Life for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| N/A | **Dependent Life for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| " | **Voluntary Life for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| " | **Short-Term Disability for** | ☐ Myself | ☐ My spouse* | ☐ My spouse and dependents | ☐ My dependents | ☐ Myself, my spouse and my dependents |
| " | **Long-Term Disability 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 Section ⑨)

☐ Covered under a Medicare supplement plan ☐ Other (please explain)_____

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

* The use of the term "spouse" in Section 12 includes a legal spouse, domestic partner or party to a civil union. All of the provisions of this section of the form that pertain to a spouse also apply to a domestic partner or party to a civil union unless specifically noted otherwise.

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

| | |
|---|---|
| العربية<br>Arabic | إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984. |
| 繁體中文<br>Chinese | 如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。 |
| Français<br>French | Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984. |
| Deutsch<br>German | Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an. |
| Ελληνικά<br>Greek | Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984. |
| ગુજરાતી<br>Gujarati | જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો. |
| हिंदी<br>Hindi | यदि आपके, या आप जिसकी सहायता कर रहे है उसके, प्रश्न है, तो आपको अपनी भाषा मे निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।. |
| Italiano<br>Italian | Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984. |
| 한국어<br>Korean | 만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오. |
| Diné<br>Navajo | T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984. |
| Polski<br>Polish | Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984. |
| Русский<br>Russian | Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984. |
| Español<br>Spanish | Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984. |
| Tagalog<br>Tagalog | Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984. |
| اردو<br>Urdu | اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔ |
| Tiếng Việt<br>Vietnamese | Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984. |

BlueCross BlueShield of Illinois

**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
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
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
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html