



Blue Cross BlueShield of Illinois

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: 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, married, no longer full-time student, 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.** 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. Medical: [] Traditional [] BlueChoice Select [] CPO [] PPO [] BlueEdge Select HSA [] CPO Value Choice [] HMO Illinois [] Integrated with BCBSIL Vendor [] Vision [] BlueAdvantage HMO [] Non-integrated [] Hearing [] BlueEdge HSA [] BlueEdge Select HCA [] Medicare Supplement [] Integrated with BCBSIL Vendor [] BlueDecision PPO [] Non-integrated [] PPO Value Choice [] BlueEdge HCA 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) Fort Dearborn Life Group #: Previous BC (Illinois) or HMO Membership: Group #: Section #: Identification #: 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: [] Marriage [] Divorce [] Age Limit [] Other: CANCEL (Check all that apply): [] Terminate Coverage [] Waive Coverage ** [] Leave/Layoff [] Out of Service Area Move [] Other: NOTE: Only list dependents to be added or dropped in the Family Coverage Information Section 7. *After checking the appropriate physician change, circle reason: [] PCP [] WPHCP **If not electing coverage, please read, complete and sign Section 11. 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

6 EMPLOYEE INFORMATION: Company Name:

Last Name: First Name: Mid. Initial: E-Mail Address:

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

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 B: ESRD DIALYSIS: DISABILITY: MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___

Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

7 A SPOUSE: 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#:

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: ___/___/___

Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

EMPLOYEE AND DEPENDENT INFORMATION:	Company Name: _____	Group #: _____
Employee Last Name: _____	Employee First Name: _____	Mid. Initial: _____

7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

7 B SON DAUGHTER: Date of Birth: ___/___/___ Last Name (Only If Different): _____ First Name: _____
 Social Security Number: _____ If HMO: Medical Group/PA #: _____
 Medical Group/PA Name: PCP #: _____ PCP Name: _____ WPHCP Medical Group/PA #: _____
 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: _____
 Social Security Number: _____ If HMO: Medical Group/PA #: _____
 Medical Group/PA Name: PCP #: _____ PCP Name: _____ WPHCP Medical Group/PA #: _____
 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: _____
 Social Security Number: _____ If HMO: Medical Group/PA #: _____
 Medical Group/PA Name: PCP #: _____ PCP Name: _____ WPHCP Medical Group/PA #: _____
 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 FORT DEARBORN LIFE:

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 Fort Dearborn Life Insurance Company (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: _____