



## APPLICATION AND POLICY CHANGE

# DIRECTIONS FOR COMPLETING APPLICATION FORM

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Detach these instructions from the application before beginning. Use black or blue ballpoint pen only. Print neatly. Do not abbreviate. **PRESS HARD.**

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 see your GROUP ADMINISTRATOR.**

- 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).

**Late Enrollment:** You are enrolling at the time other than when first becoming eligible or after a Special Enrollment period ends.

**COBRA:** You are eligible for continuation of your group health coverage.

**Retiree:** You are eligible for your group health coverage as a retired employee.

**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:** If known, enter effective date, and your Group, Section and Identification Numbers.

- ③ **COBRA/IL Continuation:** If you are a COBRA/IL Continuation enrollee, enter the 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.

- ④ **COVERAGE APPLIED FOR:** Check all coverages that you are enrolling for based on the plans offered by your employer. If you previously had Blue Cross 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 ⑦.) **If you are declining coverage, read, complete and sign Sections ⑤ and ⑪.**

- ⑤ **CHANGES TO EXISTING MEMBERSHIP:** Check all boxes that apply to change coverage, add or cancel dependents, or cancel coverage. If you are changing your PCP or WPHCP, circle the reason(s) why at the bottom of this section.

**NOTE: Medical Group/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 ⑦. If coverage is changing from Individual to Family, check the appropriate box in Section ⑥. See your Group Administrator 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 ⑦. If coverage is changing from Family to Individual, check the appropriate box in Section ⑥.

⑥ **EMPLOYEE INFORMATION: Answer every question that applies to you.**

If changing name and/or address, check the appropriate box in Section ⑤ and enter your **NAME** and **ADDRESS** in section ⑥. 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 purposes only.

If you selected **HMO** coverage in Section ④, you must select a Medical Group or IPA and a Primary Care Physician (PCP) for **each person to be covered**. You must also select a Primary Care Physician within the selected Medical Group/IPA for **each person to be covered**. You may choose a different Medical Group/IPA for each person. 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. Until we receive your selected medical group information you are not eligible to receive medical services and your claims will 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 claim 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) Dialysis, 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.

⑦ **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** — Enter complete information for your spouse. If you selected HMO coverage in Section ④, or your spouse is covered by Medicare, complete the HMO and Medicare sections as instructed in Section ⑥.

B) **CHILDREN** — Enter complete information for your child(ren). If you selected HMO coverage in Section ④, or your dependent(s) is covered by Medicare, complete the HMO and Medicare sections as instructed in Section ⑥. 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.

C) **OTHER DEPENDENT INFORMATION** — 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 BlueChoice Select coverage, your dependents must live within the defined service area.

⑧ **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.

⑨ **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.

⑩ **SIGNATURE LINE FOR NEW/CHANGING COVERAGE:** Please read, date and sign this Section. **Your signature is required.**

⑪ **SIGNATURE LINE IF DECLINING COVERAGE:** If you are declining coverage, please read this Section and check the appropriate box identifying for whom you are declining coverage and the reason. **Your signature is required.**



**APPLICATION AND POLICY CHANGE**

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

<b>1 ENROLLEE:</b> New Enrollment: <input type="checkbox"/> Timely <input type="checkbox"/> Special <input type="checkbox"/> Late		<b>Open Enrollment:</b> <input type="checkbox"/> New Member <input type="checkbox"/> Plan Change <input type="checkbox"/> Add Dependents	
<b>2 EFFECTIVE DATE:</b> ___/___/___		<b>Group Number:</b> _____	
<b>Section Number:</b> _____		<b>Identification Number:</b> _____	
<b>3 COBRA / Illinois Continuation Section</b> Employee Status: <input type="checkbox"/> Active Employee <input type="checkbox"/> COBRA Continuation <input type="checkbox"/> IL Continuation <input type="checkbox"/> Retiree, retirement date ___/___/___			
<input type="checkbox"/> <b>COBRA:</b> Start Date ___/___/___ Projected End Date ___/___/___		<input type="checkbox"/> <b>IL Continuation Privilege:</b> Start Date ___/___/___ Projected End Date ___/___/___	
Previously covered with group as: <input type="checkbox"/> 1. Employee (termination of employment, reduction in hours, other.) <input type="checkbox"/> 3. Dependent (reach age limit, other.) <input type="checkbox"/> 2. Spouse (divorce from employee, death of employee, other.) <input type="checkbox"/> 4. Spouse and Dependents (divorce from employee, death of employee, other.)			
<b>4 COVERAGE APPLIED FOR: Check all that apply.**</b>		<b>5 CHANGES TO EXISTING MEMBERSHIP: Check all that apply.</b>	
After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.			
<b>Medical</b> <input checked="" type="checkbox"/> Traditional <input type="checkbox"/> HMO Illinois <input type="checkbox"/> w/HCA (BlueEdge HMO) <input type="checkbox"/> BlueAdvantage HMO <input type="checkbox"/> w/HCA (BlueEdge HMO) <input type="checkbox"/> BlueEdge HSA <input checked="" type="checkbox"/> PPO <input type="checkbox"/> BlueEdge HCA <input type="checkbox"/> BlueChoice Select <input type="checkbox"/> BlueEdge Select HSA <input type="checkbox"/> BlueEdge Select HCA <input type="checkbox"/> BlueEdge Direct HCA <input type="checkbox"/> BlueEdge Select Direct HCA <input type="checkbox"/> BlueDecision PPO <input type="checkbox"/> PPO Value Choice <input type="checkbox"/> CPO <input type="checkbox"/> CPO Value Choice <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> Medicare Supplement		<b>CHANGES</b> Date: ___/___/___ <input type="checkbox"/> HMO Medical Group/IPA <input type="checkbox"/> PCP and/or WPHCP <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Telephone <input type="checkbox"/> Reinstale <input type="checkbox"/> From PPO to HMO <input type="checkbox"/> From HMO to PPO <input type="checkbox"/> From HMOI to BA HMO <input type="checkbox"/> From BA HMO to HMOI <input type="checkbox"/> Medicare Coverage <input type="checkbox"/> FDL Beneficiary	
_____ \$1000 Deductible _____ \$2600 Deductible		<b>ADD DEPENDENTS</b> Date: ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Placement <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Other: _____  <b>CANCEL DEPENDENTS</b> Date: ___/___/___ <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Other: _____  <b>CANCEL (Check all that apply)</b> Date: ___/___/___ <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Waive Coverage** <input type="checkbox"/> Leave/Layoff <input type="checkbox"/> Out of Service Area Move <input type="checkbox"/> Other: _____  <b>NOTE:</b> Only list dependents to be added or dropped in the Family Coverage Information Section 7.	
<b>*After checking the appropriate physician change, circle reason:</b> <input type="checkbox"/> PCP <input type="checkbox"/> WPHCP  <b>** If not electing coverage, please read, complete and sign Section 11.</b>		<b>A. Availability</b> <b>B. PCP moved office</b> <b>C. Location</b> <b>D. PCP added to Network</b> <b>E. Dissatisfied with PCP</b> <b>F. PCP office/facility undesirable</b> <b>G. Staff</b> <b>H. Other</b> _____	
<b>6 EMPLOYEE INFORMATION:</b> Company Name: _____			
Last Name: _____		First Name: _____	
Mid. Initial: _____		E-Mail Address: _____	
Street Address: _____		City: _____	
Ap. No.: _____		State: _____ Zip: _____	
Date of Birth: ___/___/___ Are You Eligible for Family Coverage: <input type="checkbox"/> No <input type="checkbox"/> Yes Health Coverage Elected: <input type="checkbox"/> Individual/Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family			
Gender: <input type="checkbox"/> Male <input type="checkbox"/> 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: <input type="checkbox"/> Actively at Work <input type="checkbox"/> Retired If retired, retirement date: _____ <input type="checkbox"/> COBRA/IL Continuation			
<b>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.</b>			
Are you covered under your employer's health care plan and also covered by Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, the section below <b>must</b> be completed:			
HIC #: _____		MEDICARE B: _____	
MEDICARE A: _____		ESRD DIALYSIS: _____	
Start Date: ___/___/___		Start Date: ___/___/___	
End Date: ___/___/___		Start Date: ___/___/___	
		End Date: ___/___/___	
<b>7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.</b>			
<b>7 A SPOUSE/DOMESTIC PARTNER:</b> Date of Birth: ___/___/___ Last Name (Only if Different): _____			
First Name: _____		Social Security Number: _____	
If HMO: Medical Group/IPA #: _____		Medical Group/IPA Name: _____	
PCP #: _____		WPHCP Medical Group/IPA #: _____	
PCP Name: _____		WPHCP Medical Group Name: _____	
WPHCP (Physician) #: _____		WPHCP (Physician) Name: _____	
		If BlueCare Dental HMO: Office ID#: _____	
<b>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.</b>			
Is this dependent covered under your employer's health care plan and also covered by Medicare? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, the section below <b>must</b> be completed:			
HIC #: _____		MEDICARE B: _____	
MEDICARE A: _____		ESRD DIALYSIS: _____	
Start Date: ___/___/___		Start Date: ___/___/___	
End Date: ___/___/___		Start Date: ___/___/___	
		End Date: ___/___/___	

<b>EMPLOYEE AND DEPENDENT INFORMATION:</b>		Company Name: _____	Group #: _____
Employee Last Name: _____		Employee First Name: _____	Mid. Initial: _____
<b>7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.</b>			
<b>7 B</b> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ <input type="checkbox"/> 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#: _____ <b>Is this dependent covered under your employer's health care plan and also covered by Medicare?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, the section below <u>MUST</u> be completed:</b> HIC #: _____ MEDICARE B: _____ ESRD DIALYSIS: _____ DISABILITY: _____ MEDICARE A: _____ Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ <input type="checkbox"/> 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#: _____ <b>Is this dependent covered under your employer's health care plan and also covered by Medicare?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, the section below <u>MUST</u> be completed:</b> HIC #: _____ MEDICARE B: _____ ESRD DIALYSIS: _____ DISABILITY: _____ MEDICARE A: _____ Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____			
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ <input type="checkbox"/> 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#: _____ <b>Is this dependent covered under your employer's health care plan and also covered by Medicare?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes <b>If Yes, the section below <u>MUST</u> be completed:</b> HIC #: _____ MEDICARE B: _____ ESRD DIALYSIS: _____ DISABILITY: _____ MEDICARE A: _____ Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____ Start Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____ End Date: ____/____/____			
<b>8 OTHER INSURANCE INFORMATION:</b>			
If you or any of your family members have OTHER GROUP COVERAGE, <b>Check all that apply.</b> <input type="checkbox"/> Health: Policy #: _____ <input type="checkbox"/> Dental: Policy #: _____ <input type="checkbox"/> Prescription Drug Coverage: Policy #: _____ <input type="checkbox"/> Vision: Policy #: _____ <input type="checkbox"/> Hearing: Policy #: _____ <b>If Yes:</b> Is the other insurance: <input type="checkbox"/> Single Coverage <input type="checkbox"/> Family Coverage EMPLOYED BY: _____ Insured's Name: _____ Date of Birth: ____/____/____ Insurance Company Name: _____ Address: _____ City: _____ State: _____ Zip: _____ Telephone Number: _____			
<b>9 DEARBORN NATIONAL:</b>			
Employee Job Title: _____ Class Type: _____ Basic Salary: \$ _____ <input type="checkbox"/> Hourly <input type="checkbox"/> Weekly <input type="checkbox"/> Semi-Monthly <input type="checkbox"/> Monthly <input type="checkbox"/> Annually Check Coverage Applied For: Term Life/AD&D: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ Dependent Life: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ Weekly Income: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ Supplemental Life: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ Long Term Disability: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ Voluntary AD&D: \$ _____ <input type="checkbox"/> Single <input type="checkbox"/> Family Permanent Life Insurance: <input type="checkbox"/> No <input type="checkbox"/> Yes \$ _____ <b>If Yes:</b> <input type="checkbox"/> Automatic Premium Loan or <input type="checkbox"/> Replaces An Existing Policy <b>BENEFICIARY: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated.</b> Last Name: _____ First Name: _____ Relationship: _____			
<b>10</b> 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: _____			
<b>11</b> 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. <b>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.</b> Not enrolling for: <input type="checkbox"/> Myself <input type="checkbox"/> My spouse <input type="checkbox"/> My spouse and dependents <input type="checkbox"/> My dependents <input type="checkbox"/> Myself, my spouse and my dependents Reason: <input type="checkbox"/> Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in 8) <input type="checkbox"/> Covered under a Medicare supplement plan <input type="checkbox"/> 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.