

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	CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
<input type="checkbox"/> Traditional <input type="checkbox"/> BlueChoice Select <input type="checkbox"/> CPO <input type="checkbox"/> PPO <input type="checkbox"/> BlueEdge Select HSA <input type="checkbox"/> CPO Value Choice <input type="checkbox"/> HMO Illinois <input type="checkbox"/> Integrated with BCBSIL Vendor <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> BlueAdvantage HMO <input type="checkbox"/> Non-integrated <input type="checkbox"/> Vision <input type="checkbox"/> BlueEdge HSA <input type="checkbox"/> BlueEdge Select HCA <input type="checkbox"/> Hearing <input type="checkbox"/> Integrated with BCBSIL Vendor <input type="checkbox"/> BlueDecision PPO <input type="checkbox"/> Medicare Supplement <input type="checkbox"/> Non-integrated <input type="checkbox"/> PPO Value Choice <input type="checkbox"/> BlueEdge HCA	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"/> Reinstate <input type="checkbox"/> From PPO to HMO <input type="checkbox"/> From HMO to PPO <input type="checkbox"/> From HMO to BA HMO <input type="checkbox"/> From BA HMO to HMO <input type="checkbox"/> Medicare Coverage <input type="checkbox"/> FDL Beneficiary	Date: ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Placement <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Other: _____	Date: ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Other: _____	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: _____
Dental <input type="checkbox"/> Individual / Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Family Enter Dental Group number if different than Medical Group policy number. <input type="checkbox"/> Dental Group #: _____ <input type="checkbox"/> BlueCare Dental PPO <input type="checkbox"/> 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 #: _____	NOTE: Only list dependents to be added or dropped in the Family Coverage Information Section (7). *After checking the appropriate physician change, circle reason: <input type="checkbox"/> PCP <input type="checkbox"/> WPHCP **If not electing coverage, please read 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: _____
 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 E-Mail Address: _____
 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: ___/___/___ 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: ___/___/___ 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.		
<input checked="" type="checkbox"/> <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ 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? <input type="checkbox"/> No <input type="checkbox"/> 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: ____/____/____		
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ 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? <input type="checkbox"/> No <input type="checkbox"/> 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: ____/____/____		
<input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____ 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? <input type="checkbox"/> No <input type="checkbox"/> 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. <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 #: _____ If Yes: 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: _____		
9 FORT DEARBORN LIFE:		
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 \$ _____ If Yes: <input type="checkbox"/> Automatic Premium Loan or <input type="checkbox"/> Replaces An Existing Policy BENEFICIARY: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated. Last Name: _____ First Name: _____ Relationship: _____		
<input checked="" type="checkbox"/> 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: _____		
<input type="checkbox"/> 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: <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 Date Signed: ____/____/____ Signature of Applicant: _____		