

## 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. Female members may choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP, however the PCP and WPHCP must have a referral arrangement with one another. 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) **DEPENDENTS** — 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.

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 **FORT DEARBORN LIFE: If you are enrolling with Fort Dearborn Life, 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.

Form with sections 1-7: ENROLLEE, EFFECTIVE DATE, COBRA/IL Continuation, COVERAGE APPLIED FOR, EMPLOYEE INFORMATION, and FAMILY COVERAGE INFORMATION.



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

**7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.**

**(B) SON**  **DAUGHTER:** 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 #: \_\_\_\_\_  
 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/IPA #: \_\_\_\_\_  
 Medical Group/IPA Name: \_\_\_\_\_ PCP #: \_\_\_\_\_ 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: \_\_\_\_\_  
 Social Security Number: \_\_\_\_\_ **If HMO:** Medical Group/IPA #: \_\_\_\_\_  
 Medical Group/IPA Name: \_\_\_\_\_ PCP #: \_\_\_\_\_ 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 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:** \_\_\_\_\_