BlueCross BlueShield of Illinois

Dearborn National®*

APPLICATION AND POLICY CHANGE

DIRECTIONS FOR COMPLETING APPLICATION FORM

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 OF BENEFITS:** 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), 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, 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 ④, or your spouse, domestic partner, or civil union partner 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.**

BlueCross BlueShield of Illinois

Dearborn National®

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 OF BENEFITS:** ___/___/___	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.)
☐ 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.)

④ COVERAGE APPLIED FOR: 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
☐ HMO Illinois
  ☐ w/HCA (BlueEdge HMO)
☐ BlueAdvantage HMO
  ☐ w/HCA (BlueEdge HMO)
☐ BlueEdge HSA

☐ PPO
☐ BlueEdge HCA
☐ Blue*Choice* Select
☐ BlueEdge Select HSA
☐ BlueEdge Select HCA
☐ BlueEdge Direct HCA
☐ BlueEdge Select Direct HCA
☐ Blue Choice Options

☐ BlueDecision PPO
☐ PPO Value Choice
☐ CPO
☐ CPO Value Choice
☐ Vision
☐ Hearing
☐ Medicare Supplement

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)

Dearborn National Group #: _____

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____

Identification #: _____

⑤ 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 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 ___/___/___
☐ Divorce
☐ Age Limit
☐ Other: _____

NOTE:
Only list dependents to be added or dropped in the Family Coverage Information Section U.

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
C. Location
E. Dissatisfied with PCP
G. Staff

B. PCP moved office
D. PCP added to Network
F. PCP office/facility undesirable
H. Other _____

**If not electing coverage, please read, complete and sign Section ⑪.

20005.1114

⑥ **EMPLOYEE INFORMATION:**	Company Name:	
Last Name:	First Name:	Mid. Initial
E-Mail Address:	Cell Phone Number:	
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

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.

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Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union ☐ Male ☐ Female 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#:_____

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.

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: ___/___/___

⑥ **EMPLOYEE AND DEPENDENT INFORMATION:**	Company Name:	Group #:
Employee Last Name:	Employee First Name:	Mid. Initial
⑦ **FAMILY COVERAGE INFORMATION:**	List All Eligible Dependents.	

⑦Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (Only If Different): ______________________________ First Name: ____________________ ☐ 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#: ______________________

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: ____________________ ☐ 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#: ______________________

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: ____________________ ☐ 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#: ______________________

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 DEARBORN NATIONAL:

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 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: _____

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: _____

*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.