BlueCross BlueShield of Illinois

Dearborn National*

ENROLLMENT APPLICATION AND POLICY CHANGE

① **ENROLLEE:** **New Enrollment:** ☐ Timely ☐ Special **Open Enrollment:** ☐ New Member ☐ Plan Change ☐ Add Dependents

② **EFFECTIVE DATE OF BENEFITS:** ___/___/___ Group #: Section #: Identification #:
☐ Completion of Other Eligibility Requirements

③ **EMPLOYEE/FORMER EMPLOYEE STATUS**
☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date ___/___/___

④ **COBRA / ILLINOIS CONTINUATION**

☐ 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)

⑤ **COVERAGE APPLIED FOR:**

__________ HMO Illinois

__________ PPO 500

__________ PPO 750

__________ HDHP 1500

⑥ **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 HMO Illinois to Blue Advantage HMO
☐ From Blue Advantage HMO to HMO Illinois
☐ Medicare Coverage
☐ FDL Beneficiary
☐ Other: __________

ADD DEPENDENTS
Date ___/___/___
☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: __________

CANCEL DEPENDENTS
Date ___/___/___
☐ Divorce**
☐ Age Limit
☐ Other: __________

CANCEL (Check all that apply)
Date ___/___/___
☐ 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 ⑧.

† After checking the appropriate physician change, circle reason:
☐ PCP ☐ WPHCP

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 __________

‡ If not electing coverage, please read, complete and sign Section ⑫.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

* Products and services marketed under the Dearborn National® brand and the star logo are underwritten and/or provided by Dearborn National® Life Insurance Company (Downers Grove, IL) and certain of its affiliates. Dearborn National® Life Insurance Company is a separate company that does not provide Blue Cross and Blue Shield of Illinois products or services.

** The term "divorce" in Section 4 includes legal divorce and the comparable termination of a civil union or domestic partnership.

⑦ **EMPLOYEE INFORMATION:**	Company Name:	Group #:
Employee Last Name:	Employee First Name:	Mid. Initial
Email Address:	Cell Phone #:	
Street Address:	Apt. #:	
City:	State:	ZIP code:

Date of Birth: ___/___/___ Are You Eligible for Family Coverage: ☐ No ☐ Yes

Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Party to a Civil Union or Domestic Partner ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security #: ________ — ______ — ___________

Employee Identification # (if known): ______________________________

Telephone #: Business: (_____) ________________ Home: (_____) ________________ Date of Hire: ___/___/___

Dept. #: ________________ Payroll Location: ____________________ Employee Clock #: ________________

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 #: ____________________ If BlueCare Dental HMO, Office ID #: ________________

Employment Status: ☐ Actively at Work ☐ COBRA/IL Continuation ☐ Retired If retired, retirement date:________________

Are you covered or applying for coverage under your employer's health care plan, and are you 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 **FAMILY COVERAGE INFORMATION:** List all eligible dependents.

⑧Ⓐ ☐ Spouse ☐ Domestic Partner ☐ Party to a Civil Union

Gender: ☐ Male ☐ Female

Last Name (only if different): ______________________________ Date of Birth: ___/___/___

First Name: ______________________________ Social Security #: ________ — ________ — ___________

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 #:____________________

Are you covered or applying for coverage under your employer's health care plan, and are you 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 **FAMILY AND DEPENDENT COVERAGE INFORMATION:**

List all eligible dependents: *If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form. If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application.*

⑧Ⓑ ☐ SON ☐ DAUGHTER Date of Birth: ___/___/___

Last Name (only if different): ______________________ First Name: ______________

☐ ELIGIBLE MILITARY PERSONNEL ☐ DISABLED DEPENDENT

Address (if different from employee's address): ______________________________

Social Security #: ______ — ______ — ________ **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 #: ______________

Are you covered or applying for coverage under your employer's health care plan, and are you 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 ☐ DISABLED DEPENDENT

Address (if different from employee's address): ______________________________

Social Security #: ______ — ______ — ________ **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 #: ______________

Are you covered or applying for coverage under your employer's health care plan, and are you 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 ☐ DISABLED DEPENDENT

Address (if different from employee's address): ______________________________

Social Security #: ______ — ______ — ________ **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 #: ______________

Are you covered or applying for coverage under your employer's health care plan, and are you 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: ___/___/___

⑨ 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 code: ___________ Telephone #: ______________________

⑩ DEARBORN NATIONAL:

The group Term Life & AD&D, STD and LTD products are underwritten by Dearborn National® Life Insurance Company.

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: ______________________

⑪ **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: ______________________

⑫ If you are declining enrollment for yourself and/or eligible dependents (children, spouse, party to a civil union or domestic partner) 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 in:

Medical for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Dental for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Vision for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Basic Life for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Dependent Life for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Voluntary Life for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Short-Term Disability for	☐ Myself	☐ My spouse*	☐ My spouse and dependents	☐ My dependents	☐ Myself, my spouse and my dependents
Long-Term Disability 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 Section ⑨)

☐ Covered under a Medicare supplement plan ☐ Other (please explain)______________________

Date Signed: ___/___/___ Signature of Applicant: ______________________

* The use of the term "spouse" in Section 12 includes a legal spouse, domestic partner or party to a civil union. All of the provisions of this section of the form that pertain to a spouse also apply to a domestic partner or party to a civil union unless specifically noted otherwise.