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

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
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 ⑪.

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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: _____

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.