



APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

Form sections: 1 ENROLLEE: New Enrollment, Open Enrollment; 2 EFFECTIVE DATE, Group Number, Section Number, Identification Number; 3 COBRA / Illinois Continuation Section; 4 COVERAGE APPLIED FOR; 5 CHANGES TO EXISTING MEMBERSHIP; 6 EMPLOYEE INFORMATION; 7 FAMILY COVERAGE INFORMATION.



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 #: _____ 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 #: _____ 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 #: _____ 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: _____			
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: <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 Reason: <input type="checkbox"/> Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧) <input type="checkbox"/> Covered under a Medicare supplement plan <input type="checkbox"/> Other (please explain) _____ Date Signed: ____/____/____ Signature of Applicant: _____			