ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM

Use a black or blue ballpoint pen only. Print neatly. Do not abbreviate.

SECTION 1 ENROLLMENT EVENTS

Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection.

New Enrollee: Complete all sections where applicable.

Add Dependent: Complete all sections where applicable.

- If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section.
- If your employer offers coverage for children and your children are eligible, 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 are adding an eligible military personnel dependent who is over the age limit of the employer's plan, completion of a Defense Department Form (DD 214) is required in addition to this application.

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.

Special Enrollment Event: If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption or placement for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment.

Effective Date of Benefits: Field is mandatory and should reflect your requested date.

Completion of Other Eligibility Requirements: Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period.

Cancel Enrollee/Cancel Dependent/Cancel Coverage: Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.

SECTION 2 YOUR INFORMATION

Complete this section with details about yourself even if you are declining coverage.

SECTION 3 YOUR COVERAGE

Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example: S533PPO) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer.

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.

SECTION 4 COVERAGE OPTIONS

Complete all areas that apply to you and each dependent.

For HMO Plans Only:

- Those applying for HMO coverage are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at **bcbsil.com**. Be sure to check the appropriate box for a new patient.
- If you selected HMO coverage, you must select a medical group/individual practice associations (IPAs) and a primary care physician (PCP) for each person to be covered. You must also select a PCP within the selected medical group/IPA for each person to be covered. You may choose a different medical group/IPA for each person. Care received from a woman's principal health care provider (WPHCP) may be eligible for coverage without referrals from your PCP. However, your PCP and your WPHCP must be affiliated with or employed by your medical group/IPA in order for each person to be eligible for coverage. Until we receive your selected medical group/IPA, you may not be eligible and your claims may be denied. Be sure to enter the medical group/IPA number, name, PCP number and name.
- 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.

Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, name and number of the new PCP and the name and number of the new IPA.

Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.

SECTION 5 DISABLED DEPENDENT

A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if dependent coverage is part of your employer's plan. The disabled dependent is required to be covered prior to age 26 to be eligible for coverage over the dependent child age limit of your employer's plan. A Disabled Dependent Certification and Disabled Dependent Physician Certification document must be completed and submitted with this enrollment application, if applicable.

SECTION 6 OTHER COVERAGE

Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.

SECTION 7 MEDICARE COVERAGE

Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.

SECTION 8 DECLINATION OF COVERAGE

Complete this section if you are declining health coverage for yourself and your dependents. **Anyone** declining coverage for any reason should complete Section 8, not just those declining because of other coverage.

IMPORTANT NOTICE: If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, party to a civil union, birth, adoption, becoming a party in a suit for adoption, or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement for adoption, or placement of an eligible foster child in your home.

SECTION 9 COVERAGE CONDITIONS

Sign your name and date the enrollment application if you agree to the conditions set forth in this section. Your enrollment application should be submitted to your employer's **Enrollment Department**, which will then submit your form to BCBSIL.

As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.

** The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).*

*** The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).*

**** The term "spouse" includes a legal spouse and a party to a civil union or domestic partnership (coverage subject to your employer's plan).*

Changes in state or federal law or regulations, or interpretations thereof, may change the terms and conditions of coverage.

If you are a current member and have questions, you may call the Customer Service number on the back of your member ID card.

ENROLLMENT APPLICATION/CHANGE FORM

BlueCross BlueShield of Illinois

Dearborn National

Group #

Account #

Section #

Social Security #

Category

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☑ **New Enrollee** ☐ **Add Dependent** ☐ **Open Enrollment** ☐ **Other Changes**

Are you applying as a result of a Special Enrollment Event?

☐ **No** ☑ **Yes, Event Date:** 11 / 12 / 2018

Event: ☑ New Hire ☐ Marriage* ☐ Birth

☐ Adoption, Placement for Adoption or Suit for Adoption (provide legal documents)

☐ Court Order (provide court order or decree)

☐ Loss of Other Coverage

☐ Other (explain): _____

Effective Date of Benefits: ____ / ____ / ____ ☐ **Completion of Other Eligibility Requirements**

☐ **Cancel Enrollee** ☐ **Cancel Dependent**

Cancel Coverage: ☐ Health ☐ Dental

☐ Term Life ☐ Dependent Life

☐ Short-Term Disability ☐ Long-Term Disability

List names of those canceling in Section 4 below

Event: ☐ Divorce** ☐ Death

☐ Terminated Employment ☐ Other

Indicate Event Date: ____ / ____ / ____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

Last Name	First Name	MI (opt)	Suffix	Birth Date (MM/DD/YYYY)	Social Security #
Burke	Sam	D		11/02/1989	X X X-X X X X X

Mailing Address - Street - Apt #	City	State	ZIP code
27W245 NORTH AVE	WEST CHICAGO	IL	60185

Email Address		Home/Cell Phone #
sburke@mobiletelltd.com	☑ Male ☐ Female	6307281997

Name of Employer	Job Title	Business Phone #	Employment Date (MM/DD/YYYY)	On average, how many hours a week do you work? (required)
Mobile Tel LTD		6302319454	01/01/2015	45

Eligibility Status: ☑ Active Employee ☐ Retired Employee - Date of Retirement: _____ ☐ COBRA Coverage Start Date _____ Projected End Date _____

☐ Illinois Continuation (insured plans only) Start Date _____ Projected End Date _____

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

Small Group Plans (1-50 Employees)

Affordable Care Act Plans

☐ PPO ☐ Other _____

☐ Blue Choice Preferred PPO℠

☐ Blue Options℠

☑ Blue Precision HMO℠

☐ BlueCare Direct℠

Plan # (required) P506PSN

Grandfathered and Grandmothered/Transitional Plans

☐ Blue Advantage Entrepreneur PPO℠ ☐ Blue Advantage HMO℠

☐ Blue Choice Select PPO℠ ☐ Blue Advantage HMO Value Choice℠

☐ BlueEdge Select HSA℠ ☐ Community Participation Organization (CPO)

☐ BlueEdge HSA℠ ☐ CPO Value Choice

☐ BlueEdge HCA Direct℠ ☐ Other _____

☐ PPO Value Choice Plan # (required) _____

Mid-Market and Large Group Standard Plans (51+ Employees)

Mid-Market & Large Group Standard Plans 51+

☐ [illegible] ☐ Blue Choice [illegible]℠ ☐ BlueEdge Sel[illegible]SA

☐ Blu[illegible]dvantage HMO℠ ☐ Blue Choice [illegible]ect PPO℠ ☐ Plan # (req[illegible]) _____

☐ Blue A[illegible]ntage HM[illegible]lue Choice℠ ☐ BlueEdg[illegible]A℠ ☐ Other _____

Previous BCBSIL or HMO Membership

G[illegible]p #: _____

[illegible]ction #: _____

[illegible]dentification #: _____

Large Group Cust[illegible]Pl[illegible](51+ Employees)

☐ Traditional

☐ PPO

☐ CPO

☐ CPO[illegible]e Choice

☐ H[illegible]Illinois®

☐ [illegible]O Illinois® w/HCA

☐ Blue Advantage HMO℠

☐ Blue Advantage [illegible]℠ w/HCA

☐ Blue Choice [illegible]ns℠

☐ Blue Choice[illegible]ect PP[illegible]

☐ BlueEdg[illegible]A℠

☐ BlueE[illegible]HSA℠

☐ Blue[illegible]e HCA Direct℠

☐ BlueEdge Select HCA℠

☐ BlueEdge Select H[illegible]

☐ BlueEdge Selec[illegible]A[illegible]ct℠

☐ Vision

☐ Hearing

☐ [illegible]edica[illegible]pplement

☐ [illegible]er _____

Dental

☐ BlueCare Dental PPO℠

☐ BlueCare Dental HMO℠

☐ Dental Group # (if different than Medical Group policy #) _____

☐ Employee and Party to a Civil Union or Domestic Partner

Gender: ☐ Male ☐ Female

☐ Individual/Employee

☐ Employee/Children

☐ Employee/Spouse

☐ Family

Primary Language: _____

Gr[illegible]Term Life, Accidental Death[illegible]Dismemb[illegible]ent (AD&D) and Disability I[illegible]nce through[illegible]born National®^

☐ I am[illegible]pplying for Group Term [illegible]D&D or Disability[illegible]ance coverage

Employee[illegible]upation/Job Title: _____ [illegible]ge Rate $_____ per ☐ hour ☐ wee[illegible] ☐ month ☐ year

Group Basic [illegible] Life and AD	☐ I do not apply	[illegible]o apply	Amount $_____	
Group Dependen[illegible]ife	☐ I do not apply	☐ [illegible]pply		
Group Supplement[illegible]	☐ I do not apply	☐ I d[illegible]		
Employee Election: _____	Spouse Election: $_____		Child Electio[illegible]	
Short-Term Disa[illegible]	☐ I do not apply	☐ [illegible]pply		
Long-Term D[illegible]y	☐ I do not apply	[illegible]o apply		

	First Name	Initial	Last Name	Relationship	Birth[illegible] (MM/DD/YYYY)	Soci[illegible]urity #
Primary Benefi[illegible]			[illegible]st Name			_
Co[illegible]nt Beneficiary	First Name	[illegible]Initial	Last Name	[illegible]tionship	[illegible]h Date (MM/DD/YYYY)	Social Secu[illegible] _ _

As used on the application (unless indicated otherwise): These terms may be used in a different way in other documents.

** The term "marriage" includes legal marriage and the establishment of a civil union or domestic partnership (coverage subject to your employer's plan).*

*** The term "divorce" includes legal divorce and the comparable termination of a civil union or domestic partnership (coverage subject to your employer's plan).*

**** The term "spouse" includes a legal spouse and party to a civil union or domestic partnership (coverage subject to your employer's plan).*

^ 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, Illinois) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico. Dearborn National® Life Insurance Company does not provide Blue Cross and Blue Shield of Illinois products and services, and is a separate company.

Last Name: Social Security #: — — Group #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY
(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.)

Employee/Enrollee's Name Sam Burke		PCP Name Dr. MD PCP # 888190XXX	IPA Name Medical Group of IL IPA # 458
WPHCP Name WPHCP #	New Patient? ☐ Y ☐ N	HMO OB/GYN Name (optional)	HMO OB/GYN #

Dependent's Name ☐ Husband ☐ Wife ☐ Domestic Partner ☐ Party to a Civil Union		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
IPA Name IPA #		WPHCP Name WPHCP #	HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Social Security # – –	Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code		

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐ Son ☐ Daughter ☐ Other Eligible Dependent		Dependent's PCP Name	PCP #	New Patient? ☐ Y ☐ N
Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code	Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption? ☐ Y ☐ N	If not your eligible natural child, stepchild, foster child, adopted child or child in suit for adoption, are you (or your spouse) responsible for this dependent? ☐ Y ☐ N	
Dependent's Social Security # – –		IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of [illegible]abled Dependent | Natu[illegible] of Disability

Name [illegible] Dependent | Na[illegible]ability

If disabled ch[illegible]ependent age limit of your employer's plan, please atta[illegible] Disabled De[illegible]fication and the Disabled Dependent Physician Certificati[illegible]

SECTION 6 – [illegible] COVERAGE INFORMATION

[illegible]ASE COMPLETE [illegible]S THAT APPLY

Complete this sec[illegible]ou or any of your dependents [illegible] health and/or dental cove[illegible]**ill not be canceled** when th[illegible] under this application becomes [illegible]**ist names of each indiv[illegible]ed**:

Group Coverage ☐ Yes ☐ No | Individua[illegible] ☐ Yes ☐ N[illegible] | Name an[illegible] Other Insurance Carrier | Effective Date [illegible] | Ty[illegible] [illegible]Only ☐ Employee/Spouse [illegible]ee/Child(ren) ☐ Family

Name of Policyholder | Birth Date (MM/DD/YYYY) | ☐ Male ☐ Female | [illegible]o Applicant [illegible]ouse ☐ Dependent

Employer's Name | [illegible]t Date (MM/DD/YYYY) | Health Group # | Health ID # | [illegible]p # | Dental ID #

SECTION 7 — MEDICAR[illegible]AGE IN[illegible]ON

PLEASE COMPLETE IF APPL[illegible]

Name of person covered: | Me[illegible]spital) Effective Date: ________ [illegible]e: ________ | [illegible]edicare HIC #
Medica[illegible]cal) Effective Date: ________ [illegible]Date: ________ | [illegible]m Medicare Card)
Medicare [illegible]fective Date: ________ [illegible]d Date: ________
Medicare D[illegible]er: ________

Please indicat[illegible] Medicare Eligibility: ☐ Entitled Age[illegible]d Disability ☐ En[illegible]nal Disease ☐ Disability and Current [illegible]se

Name of pe[illegible]d: | Medicare A (Hosp[illegible]e Date: ________ End Date: ________ | Me[illegible]
Medicare B (Medical[illegible]ate: ________ End Date: ________ | (From [illegible]rd)
Medicare D (Drug) Effe[illegible] ________ End Date: ________
Medicare D (Drug) Carrier: ________

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease

SECTION 8 — DECLINATION OF COVERAGE
PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

This is to certify the available coverage has been explained to me. I have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to decline the coverage as indicated below. If I desire to apply for coverage at a later date, I understand there may be a delay in the effective date of the coverage.

Name ☐ Employee	Reason for declining **Health**: ☐ Other Group Health Coverage - Carrier: ______ ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage - Carrier: ______ ☐ Other (explain) ______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Employee	Reason for declining **Dental**: ☐ Other Group Dental Coverage ☐ Medicaid ☐ Individual Dental Coverage ☐ Other (explain) ______ ☐ I am not enrolled in any dental insurance plan, but do not want this coverage
Name ☐ Spouse	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage
Name ☐ Dependent	Reason for declining: ☐ Other Group Health Coverage ☐ Medicare ☐ Medicaid ☐ Other Individual Health Coverage ☐ Other (explain)______ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Illinois or Dearborn National® Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

Applicant's Signature ______________________ Date ______________

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator	Phone: 855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD: 855-661-6965
35th Floor	Fax: 855-661-6960
Chicago, Illinois 60601	Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services	Phone: 800-368-1019
200 Independence Avenue SW	TTY/TDD: 800-537-7697
Room 509F, HHH Building 1019	Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Washington, DC 20201	Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html