



# APPLICATION AND POLICY CHANGE

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

<b>1 ENROLLEE:</b>	<input type="checkbox"/> Timely Enrollment <input type="checkbox"/> Special Enrollment <input type="checkbox"/> Late Enrollment <input type="checkbox"/> COBRA/IL Continuation <input type="checkbox"/> Retiree <input type="checkbox"/> Membership Change <input type="checkbox"/> Open Enrollment							
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<b>2 EFFECTIVE DATE:</b>	GROUP NUMBER:	SECTION NUMBER:	IDENTIFICATION NUMBER:	<b>3 COBRA/IL Continuation</b>	START DATE: ___/___/___	END DATE: ___/___/___	FOR USE BY BCBSIL ONLY <b>REASON CODE:</b> ___
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<b>4 COVERAGE APPLIED FOR: Check all that apply.**</b>	<b>5 CHANGES TO EXISTING MEMBERSHIP: Check all that apply.</b>
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**After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.**

<p><b>Medical</b></p> <input type="checkbox"/> Traditional <input type="checkbox"/> PPO <input type="checkbox"/> CPO (Community Participating Option) <input type="checkbox"/> BlueAdvantage HMO <input type="checkbox"/> HMO Illinois <input type="checkbox"/> Prescription Drugs <input type="checkbox"/> Vision <input type="checkbox"/> Hearing  <p><b>Dental</b>   <input type="checkbox"/> Single   <input type="checkbox"/> Family</p> <input type="checkbox"/> BlueCare Dental Traditional/PreDent <input type="checkbox"/> BlueCare Dental PPO <input type="checkbox"/> BlueCare Dental HMO/DentaCap <input type="checkbox"/> Dental Group #: _____  <p><b>Fort Dearborn Life</b>   Group #: _____</p> <p><b>Previous BC (Illinois) or HMO Membership:</b>          Group #: _____ Section #: _____          Identification #: _____</p>	<p style="text-align:center;"><b>CHANGES</b></p> Date: ___/___/___ <input type="checkbox"/> HMO Medical Group/IPA <input type="checkbox"/> PCP and/or WPHCP <input type="checkbox"/> Name <input type="checkbox"/> Address <input type="checkbox"/> Telephone <input type="checkbox"/> Reinstate <input type="checkbox"/> From PPO to HMO <input type="checkbox"/> From HMO to PPO <input type="checkbox"/> Medicare Coverage <input type="checkbox"/> FDL Beneficiary	<p style="text-align:center;"><b>ADD DEPENDENTS</b></p> Date: ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Adoption/Placement <input type="checkbox"/> Legal Guardianship <input type="checkbox"/> Other: _____  <p style="text-align:center;"><b>NOTE:</b>          Only list dependents to be added or dropped in the Family Coverage Information Section (7).</p>	<p style="text-align:center;"><b>CANCEL DEPENDENTS</b></p> Date: ___/___/___ <input type="checkbox"/> Marriage <input type="checkbox"/> Divorce <input type="checkbox"/> Age Limit <input type="checkbox"/> Other: _____  <p style="text-align:center;"><b>CANCEL (Check all that apply)</b></p> Date: ___/___/___ <input type="checkbox"/> Terminate Coverage <input type="checkbox"/> Voluntary Withdrawal ** <input type="checkbox"/> Leave/Layoff <input type="checkbox"/> Out of Service Area Move <input type="checkbox"/> Other: _____
<p><b>*After checking the appropriate physician change, circle reason:</b></p> <input type="checkbox"/> PCP <input type="checkbox"/> WPHCP <b>** If not electing coverage, please read and sign Section (11).</b>		<p><b>A. Availability      B. PCP moved office</b>  <b>C. Location        D. PCP added to Network</b>  <b>E. Dissatisfied with PCP      F. PCP office/facility undesirable</b>  <b>G. Staff                H. Other _____</b></p>	

<b>6 EMPLOYEE INFORMATION:</b>	Company Name: _____
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Last Name: _____	First Name: _____	Mid. Initial: _____
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Street Address: _____	Apt. No.: _____	City: _____	State: _____	Zip: _____
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Date of Birth: \_\_\_/\_\_\_/\_\_\_    Are You Eligible for Family Coverage:  No  Yes    Health Coverage Elected:  Individual  Family    Sex:  Male  Female

Employee Social Security Number: \_\_\_\_\_

Telephone No.: Bus.: (\_\_\_\_) \_\_\_\_\_    Home: (\_\_\_\_) \_\_\_\_\_    Date of Hire: \_\_\_/\_\_\_/\_\_\_

Dept. No.: \_\_\_\_\_    Payroll Location: \_\_\_\_\_    Employee Clock No.: \_\_\_\_\_

If HMO: Medical Group/IPA #: \_\_\_\_\_    Medical Group/IPA Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_    WPHCP Medical Group/IPA #: \_\_\_\_\_

WPHCP Medical Group Name: \_\_\_\_\_    WPHCP (Physician) Name: \_\_\_\_\_

**Employment Status:**    Actively at Work    Retired    COBRA/IL Continuation    If retired, retirement date: \_\_\_\_\_

**Are you covered under your employer's health care plan and also covered by Medicare?**    No    Yes    If Yes, please complete the section below:

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.**

**(A) SPOUSE:** Date of Birth: \_\_\_/\_\_\_/\_\_\_    Last Name (Only if Different): \_\_\_\_\_

First Name: \_\_\_\_\_    Social Security Number: \_\_\_\_\_

If HMO: Medical Group/IPA #: \_\_\_\_\_    Medical Group/IPA Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_    WPHCP Medical Group/IPA #: \_\_\_\_\_

WPHCP Medical Group Name: \_\_\_\_\_    WPHCP (Physician) Name: \_\_\_\_\_

**Is your spouse covered under your employer's health care plan and also covered by Medicare?**    No    Yes    If Yes, please complete the section below:

HIC #: \_\_\_\_\_    MEDICARE B: \_\_\_\_\_    ESRD DIALYSIS: \_\_\_\_\_    DISABILITY: \_\_\_\_\_

MEDICARE A: \_\_\_\_\_    Start Date: \_\_\_/\_\_\_/\_\_\_    Start Date: \_\_\_/\_\_\_/\_\_\_    Start Date: \_\_\_/\_\_\_/\_\_\_

Start Date: \_\_\_/\_\_\_/\_\_\_    End Date: \_\_\_/\_\_\_/\_\_\_    End Date: \_\_\_/\_\_\_/\_\_\_    End Date: \_\_\_/\_\_\_/\_\_\_



<b>EMPLOYEE INFORMATION:</b>	Company Name: _____	Group #:	
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Last Name: _____	First Name: _____	Mid. Initial: _____
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**SON**     **DAUGHTER:**    Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_    Last Name (Only If Different): \_\_\_\_\_

First Name: \_\_\_\_\_    Social Security Number: \_\_\_\_\_

If HMO: Medical Group/IPA #: \_\_\_\_\_    Medical Group/IPA Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_    WPHCP Medical Group/IPA #: \_\_\_\_\_

WPHCP Medical Group Name: \_\_\_\_\_    WPHCP (Physician) Name: \_\_\_\_\_

**Is this dependent covered under your employer's health care plan and also covered by Medicare?**     **No**     **Yes**    **If Yes, please complete the section below:**

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: \_\_\_\_\_    Social Security Number: \_\_\_\_\_

If HMO: Medical Group/IPA #: \_\_\_\_\_    Medical Group/IPA Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_    WPHCP Medical Group/IPA #: \_\_\_\_\_

WPHCP Medical Group Name: \_\_\_\_\_    WPHCP (Physician) Name: \_\_\_\_\_

**Is this dependent covered under your employer's health care plan and also covered by Medicare?**     **No**     **Yes**    **If Yes, please complete the section below:**

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: \_\_\_\_\_    Social Security Number: \_\_\_\_\_

If HMO: Medical Group/IPA #: \_\_\_\_\_    Medical Group/IPA Name: \_\_\_\_\_

Primary Care Physician Name: \_\_\_\_\_    WPHCP Medical Group/IPA #: \_\_\_\_\_

WPHCP Medical Group Name: \_\_\_\_\_    WPHCP (Physician) Name: \_\_\_\_\_

**Is this dependent covered under your employer's health care plan and also covered by Medicare?**     **No**     **Yes**    **If Yes, please complete the section below:**

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 FORT DEARBORN LIFE:**

**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 Fort Dearborn Life Insurance Company (providing the life and disability insurance) which are herein called 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. Upon presentation of the original or a photocopy of this signed authorization, I authorize any medical professional, hospital, clinic, other medical or medically related facility, government agency, or other person or firm to provide information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness, use of drugs or alcohol, to the Company representatives involved in evaluating, determining or administering claims for insurance benefits for me and my dependents. I understand that I or any authorized representative will receive a copy of this authorization upon request.

**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

**Date Signed:** \_\_\_\_/\_\_\_\_/\_\_\_\_    **Signature of Applicant:** \_\_\_\_\_