BlueCross BlueShield of Illinois

Illinois Extension Form

Indicate N/A in any sections that do not apply to your group.

This is a document to be included for multiple purposes. Please indicate the purpose for which this document has been submitted:

☐ This is a document to be included as part of a full-case submission for an offer of coverage from Blue Cross and Blue Shield of Illinois (BCBSIL). This statement applies to new business.

☐ This document is submitted for the purpose of obtaining a Stage 2 quote. If this is the case, the client should attach the full renewal (text, rates, benefits, reports, negotiations, etc.) for the purposes of obtaining a risk-adjusted proposal. The client must have 10 or more enrolled medical lives.

SECTION A

Employer Name		**Employer Tax ID #**
Type of Business	**SIC Code**	**Original Business Start-Up Date** _____/_____/_____
Parent Company Name		
Prior Group Coverage with Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company? ☐ Yes ☐ No **If Yes**, provide Cancellation Date: _____/_____/_____ Group Number: _____		
Is the Group's current funding arrangement fully insured? ☐ Yes ☐ No		What is the Group's current health coverage renewal date? _____/_____/_____

Number of Part-Time Employees: _____	Total Number Enrolled: _____	Number of Out-of-State Resident Enrollees: _____
Number of Full-Time Employees: _____	Number with Signed Waivers: _____	**List:** State / Number of Employees
Number of Union Employees: _____		_____ / _____
Number of Total Employees: _____	Number of Continuees: (State of Illinois or COBRA) _____	_____ / _____
		_____ / _____

SECTION B

INSURANCE COMPANY HISTORY (All insurance companies, including HMO, in the previous five years)

	Insurance Company Name	Period Insured
Current		_____/_____/_____ through _____/_____/_____
Previous		_____/_____/_____ through _____/_____/_____
		_____/_____/_____ through _____/_____/_____

Current Carrier Premium Rates For:	Plan Type (HMO, PPO, Other)	Current Policy	Renewal	Benefit levels (Deductible and Coinsurance)
Employee	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Employee plus Spouse	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Employee plus Child(ren)	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Family	☐ HMO ☐ PPO ☐ Other, specify _____	$ _____ $ _____ $ _____	$ _____ $ _____ $ _____	Deductible: _____ Coinsurance: _____
Total Monthly Health Premium		$ _____	$ _____	

SECTION C	This section is to be completed by groups with 51 or more average total employees.

MEDICAL QUESTIONNAIRE

Directions: Please check **Yes** or **No**. If any box is checked Yes, circle the condition, e.g., *STROKE*, and give details below.

Yes	No	Number of Members	
☐	☐		1. Has anyone had a claim of $5,000 or more in the past 12 months?
☐	☐		2. Has anyone been advised to have surgery or medical treatment in the past six months that has not yet been performed, or been hospitalized or had surgery in the past three years?
			3. Has anyone been advised, diagnosed or treated by a physician in the past five years for:
☐	☐		A. Stroke, heart, circulatory, vascular disease or disorder, or high blood pressure?
☐	☐		B. Cancer, tumors, leukemia, lupus or any other systemic disease?
☐	☐		C. Multiple sclerosis, paralysis, arthritis or bone/joint/back/muscle disorders?
☐	☐		D. Asthma, emphysema, respiratory or lung disorders?
☐	☐		E. Diabetes, pancreas, growth disorder or endocrine disorder?
☐	☐		F. AIDS, tested positive for HIV, immune system disorders or blood disorders?
☐	☐		G. Hepatitis/liver disorder, digestive system disease or disorder, colon disorder, kidney/prostate/reproductive organs disorder or infertility?
☐	☐		H. Nervous system or brain/seizure disorder, mental/emotional disorders, alcohol/drug/substance abuse or dependency?
☐	☐		I. Organ transplant or bone marrow transplant?
☐	☐		J. Other?____
☐	☐		4. Are any employees or dependents currently pregnant?

If you have answered **Yes** to any of the questions above, please provide details below.
Use an additional page if needed.

DETAILS OF MEDICAL HISTORY

Question #	Name *(optional)*	Employee, Spouse, Child	Age	Sex	Condition/ Diagnosis	Treatment Medications	Treatment Date	Date of Recovery
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____
		☐ Employee ☐ Spouse ☐ Child		☐ Male ☐ Female			____/____/_____	____/____/_____

The following information is needed to comply with Public Act 86-537, as amended, which regulates the Discontinuation and Replacement of Group Insurance policies. Each covered person will be given credit toward our participating provider program deductible for prior deductible and waiting periods satisfied under the prior carrier's coverage based on information provided to Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC") by the group. HCSC reserves the right to accept or, where not prohibited by law, reject the entire group based on the information provided. HCSC further reserves the right to change the quoted rates or withdraw the proposal if any of the above information changes, was omitted, or has been reported inaccurately.

What is the provision in the current insurance carrier's contract for coverage during layoff, leave of absence and disability?

____

What is the current carrier's extension of benefits provision for medical services in the event of employer group cancellation?

____

Has the Group's medical coverage ever been cancelled, or applications for coverage been declined or withdrawn? ☐ Yes ☐ No

If yes, explain. ____

If additional space is needed for any of the above, please attach a separate sheet with the required information.