Please read the instructions on the inside thoroughly before completing this enrollment application/change form.
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 for life or disability insurance 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 (DD 214) is required in addition to this application.

Change Primary Care Physician/Practitioner: Complete Section 1 and check the “Other Changes(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 Changes(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 Authorization 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

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: __/__/____

Event:
- New Hire
- Marriage
- Adoption, Placement for Adoption
- Court Order
- Loss of Other Coverage
- Other (explain): ______

Effective Date of Benefits: _____ / _____ / _____

- Completion of Other Eligibility Requirements

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 #:

Mailing Address - Street - Apt #:
City:
State:
ZIP code:

Email Address:

Name of Employer:
Job Title:
Business Phone #:
Employment Date (MM/DD/YYYY):
On average, how many hours a week do you work? ______

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

Affordable Care Act Plans
- PPO
- Blue Choice Preferred PPO
- Blue Options
- Blue Precision HMO
- BlueCare Direct

Plan # (required):

Grandfathered and Grandmothered/Transitional Plans
- Blue Advantage Entrepreneur PPO
- Blue Choice Select PPO
- BlueEdge Select HSA
- BlueEdge HSA
- BlueEdge HCA Direct
- PPO Value Choice

Plan # (required):

Mid-Market and Large Group Standard Plans 51+ Employees

- PPO
- Blue Advantage HMO
- Blue Choice Options
- BlueChoice Select PPO
- BlueAdvantage HMO Value Choice
- BlueEdge Select HSA

Plan # (required):

Previous BCBSIL or HMO Membership

Large Group Custom Plans 151+ Employees

- Traditional
- PPO
- CPO
- CPO Value Choice
- HMO Illinois
- HMO Illinois w/HCA
- Blue Advantage HMO

- Blue Edge Select HSA
- Blue Choice Select PPO
- BlueChoice Select PPO
- BlueEdge Select HSA
- BlueEdge HCA Direct
- BlueChoice Select PPO
- BlueEdge HCA Direct

Plan # (required):

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
- Individual/Employee
- Employee/Children
- Employee/Spouse
- Family

Primary Language:

Group Term Life, Accidental Death and Dismemberment (AD&D) and Disability Insurance

- I am not applying for Group Term Life, AD&D or Disability Insurance coverage

Employee Occupation/Job Title: ___________________________
Wage Rate $__________ per ___ hour ___ week ___ month ___ year

Group Basic Term Life and AD&D
- I do not apply
- I do apply

Amount $__________

Group Dependents’ Life
- I do not apply
- I do apply

Group Supplemental Life
- I do not apply
- I do apply

Employee Election: $__________
Spouse Election: $__________
Child Election: $__________

Short-Term Disability
- I do not apply
- I do apply

Long-Term Disability
- I do not apply
- I do apply

Primary
First Name:
Initial:
Last Name:
Relationship:
Birth Date (MM/DD/YYYY):
Social Security #:

Beneficiary
First Name:
Initial:
Last Name:
Relationship:
Birth Date (MM/DD/YYYY):
Social Security #:

Contingent
First Name:
Initial:
Last Name:
Relationship:
Birth Date (MM/DD/YYYY):
Social Security #:

Beneficiary
First Name:
Initial:
Last Name:
Relationship:
Birth Date (MM/DD/YYYY):
Social Security #:

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 “death” 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).

Life and Disability Insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.
### 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.)

<table>
<thead>
<tr>
<th>Employee/Enrollee’s Name</th>
<th>PCP Name</th>
<th>IPA Name</th>
<th>WPHCP Name</th>
<th>IPA #</th>
</tr>
</thead>
</table>

**New Patient?** □ Y □ N

<table>
<thead>
<tr>
<th>Dependent’s Name</th>
<th>Dependent’s PCP Name</th>
<th>New Patient?</th>
<th>IPA Name</th>
<th>IPA #</th>
</tr>
</thead>
</table>

**HMO OB/GYN Name (optional)**

**HMO OB/GYN #**

<table>
<thead>
<tr>
<th>Dependent’s Social Security #</th>
<th>Birth Date (MM/DD/YYYY)</th>
<th>Home Address (if different)</th>
<th>Street/City/State/ZIP code</th>
</tr>
</thead>
</table>

**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

<table>
<thead>
<tr>
<th>Dependent’s Social Security #</th>
<th>Birth Date (MM/DD/YYYY)</th>
<th>Home Address (if different)</th>
<th>Street/City/State/ZIP code</th>
</tr>
</thead>
</table>

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**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

<table>
<thead>
<tr>
<th>Dependent’s Social Security #</th>
<th>Birth Date (MM/DD/YYYY)</th>
<th>Home Address (if different)</th>
<th>Street/City/State/ZIP code</th>
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</thead>
</table>

**Is this dependent a natural child, stepchild, foster child, adopted child or a child in suit for adoption?** □ Y □ N

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<table>
<thead>
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<th>Street/City/State/ZIP code</th>
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</table>

**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

### SECTION 5 — DISABLED DEPENDENT

**PLEASE COMPLETE IF APPLICABLE**

<table>
<thead>
<tr>
<th>Name of Disabled Dependent</th>
<th>Nature of Disability</th>
</tr>
</thead>
</table>

If disabled child is over the dependent age limit of your employer’s plan, please attach a completed Disabled Dependent Certification and the Disabled Dependent Physician Certification document.

### SECTION 6 — OTHER COVERAGE INFORMATION

**PLEASE COMPLETE ALL AREAS THAT APPLY**

Complete this section only if you or any of your dependents have other health and/or dental coverage that will not be canceled when the coverage under this application becomes effective. List names of each individual covered.

<table>
<thead>
<tr>
<th>Group Coverage</th>
<th>Individual Coverage</th>
<th>Name and Address of Other Insurance Carrier</th>
<th>Effective Date (MM/DD/YYYY)</th>
<th>Type of Policy</th>
</tr>
</thead>
</table>

**Group Coverage** □ Y □ N

**Individual Coverage** □ Y □ N

**Name and Address of Other Insurance Carrier**

**Effective Date (MM/DD/YYYY)**

**Type of Policy**

**Employee Only** □

**Employee/Spouse** □

**Employee/Child(ren)** □

**Family** □

**Name of Policyholder**

<table>
<thead>
<tr>
<th>Birth Date (MM/DD/YYYY)</th>
<th>Male</th>
<th>Female</th>
<th>Relationship to Applicant</th>
</tr>
</thead>
</table>

**Name of Policyholder**

**Birth Date (MM/DD/YYYY)**

**Male** □

**Female** □

**Relationship to Applicant**

**Employer’s Name**

<table>
<thead>
<tr>
<th>Employment Date (MM/DD/YYYY)</th>
<th>Health Group #</th>
<th>Health ID #</th>
<th>Dental Group #</th>
<th>Dental ID #</th>
</tr>
</thead>
</table>

**Employer’s Name**

**Employment Date (MM/DD/YYYY)**

<table>
<thead>
<tr>
<th>Health Group #</th>
<th>Health ID #</th>
<th>Dental Group #</th>
<th>Dental ID #</th>
</tr>
</thead>
</table>

### SECTION 7 — MEDICARE COVERAGE INFORMATION

**PLEASE COMPLETE IF APPLICABLE**

<table>
<thead>
<tr>
<th>Name of person covered:</th>
<th>Medicare A (Hospital) Effective Date:</th>
<th>Medicare B (Medical) Effective Date:</th>
<th>Medicare D (Drug) Effective Date:</th>
<th>Medicare D (Drug) Carrier:</th>
</tr>
</thead>
</table>

**Name of person covered:**

<table>
<thead>
<tr>
<th>Medicare A (Hospital) Effective Date:</th>
<th>Medicare B (Medical) Effective Date:</th>
<th>Medicare D (Drug) Effective Date:</th>
<th>Medicare D (Drug) Carrier:</th>
</tr>
</thead>
</table>

**Medicare HIC #**

(From Medicare Card)

Please indicate reason for Medicare Eligibility:

□ Entitled Age □ Entitled Disability □ End-Stage Renal Disease □ Disability and Current Renal Disease

<table>
<thead>
<tr>
<th>Name of person covered:</th>
<th>Medicare A (Hospital) Effective Date:</th>
<th>Medicare B (Medical) Effective Date:</th>
<th>Medicare D (Drug) Effective Date:</th>
<th>Medicare D (Drug) Carrier:</th>
</tr>
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</table>

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<tr>
<th>Medicare A (Hospital) Effective Date:</th>
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<th>Medicare D (Drug) Effective Date:</th>
<th>Medicare D (Drug) Carrier:</th>
</tr>
</thead>
</table>

**Medicare HIC #**

(From Medicare Card)

Please indicate reason for Medicare Eligibility:

□ Entitled Age □ Entitled Disability □ End-Stage Renal Disease □ Disability and Current Renal Disease
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
<table>
<thead>
<tr>
<th>لغة</th>
<th>نص لغوي</th>
</tr>
</thead>
<tbody>
<tr>
<td>العربية</td>
<td>إن كان لديك أو لديك شخص تساعد، فإن نجاح الحق في الحصول على المساعدة والمعلومات الضرورية يغطي من دون أي تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.</td>
</tr>
<tr>
<td>國語中文</td>
<td>如果您，或您正在協助的對象，對此有疑問，您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員，請撥電話號碼 855-710-6984。</td>
</tr>
<tr>
<td>Français</td>
<td>Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.</td>
</tr>
<tr>
<td>Deutsch</td>
<td>Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.</td>
</tr>
<tr>
<td>Ελληνικά</td>
<td>Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε το 855-710-6984.</td>
</tr>
<tr>
<td>Gujarati</td>
<td>તમે તમાં અશ્રુભર તમા મદદ કુશ્ય રહ્યા હતા અંગુર તેથી તમારી જિંદગી મદદના મહત્તા માટે મદદ આની મહત્તા માટે કરો. મોટે અનુભવ કરો.</td>
</tr>
<tr>
<td>हिंदी</td>
<td>यदि आप, या आपको उसकी सहायता कर रहे हैं उसके प्रश्न हैं, तो आपको अपनी भाषा में अनेक सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुसार दे बात करने के लिए 855-710-6984 पर कॉल करें।</td>
</tr>
<tr>
<td>Italiano</td>
<td>Se tu o qualcuno che stai aiutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.</td>
</tr>
<tr>
<td>한국어</td>
<td>만약 귀하 또는 귀하를 돕는 사람이 질문이 있다면 귀하의 무료로 그려진 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984로 전화하십시오.</td>
</tr>
<tr>
<td>Diné</td>
<td>T’áá ni, éí doodago łá’da bítá anáníwo’íí, na’idiłkidgo, ts’ídá bee na ahóóti’i’i t’áá niik’e níká a’doolhwól dóó bina’idiłkidíígií bee nií h odooninh. Ata’dañalne’ííghi bich’i’h odiñilníh kwe’è 855-710-6984.</td>
</tr>
<tr>
<td>Polski</td>
<td>Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.</td>
</tr>
<tr>
<td>Russian</td>
<td>Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.</td>
</tr>
<tr>
<td>Español</td>
<td>Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.</td>
</tr>
<tr>
<td>Tagalog</td>
<td>Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuhang tulog at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawagan sa 855-710-6984.</td>
</tr>
<tr>
<td>Urdu</td>
<td>اگر آپ کو یا کسی دوسرے کو جس کی کسی مدد کریں گئے ہیں، کیونکہ یہ واقعہ جو ہم، آپ کو اپنے زبان میں مفت مدد اور معلومات حاصل کریں گے۔ ہم مترجم سور سے بات کرتے ہیں، مترجم سور سے بات کرتے ہیں، 855-710-6984 پر کال کریں۔</td>
</tr>
<tr>
<td>Tiếng Việt</td>
<td>Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thợ dịch việt, gọi 855-710-6984.</td>
</tr>
</tbody>
</table>