



**BlueCross BlueShield**

Illinois • Montana • New Mexico • Oklahoma • Texas

Producer Experience Portal

# Producer Experience Portal: IFM Enrollment User Guide

## Purpose:

The Producer Experience Portal enables you to design and deliver quotes, enroll clients in Blue plans and manage prospects. This section covers submitting enrollment for off-exchange Individual and Family Market ACA medical and dental plans.

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# Quote & Enroll Tab

Producer can Navigate to Enrollment process in three different ways after navigating to Quote & Enroll tab:

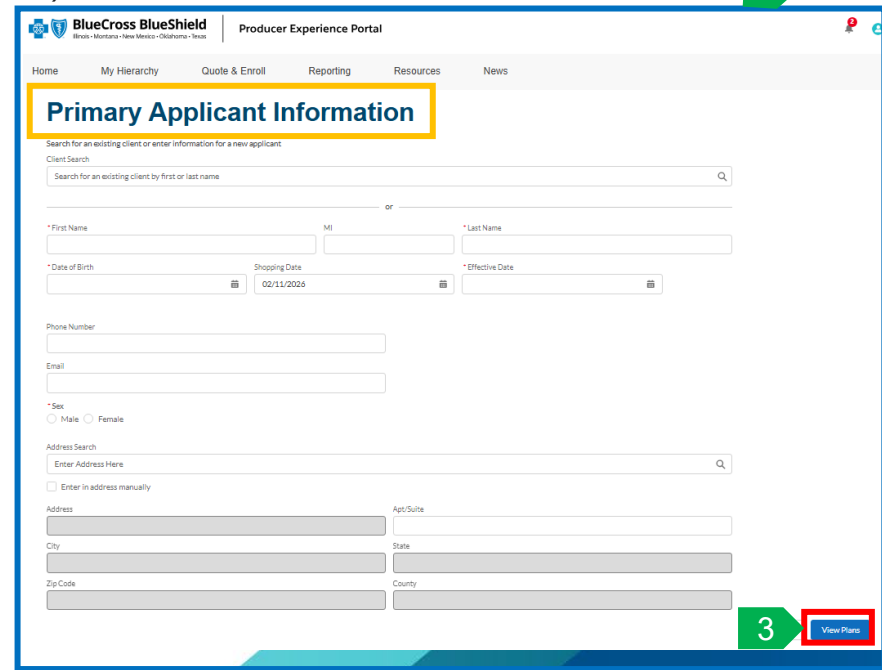
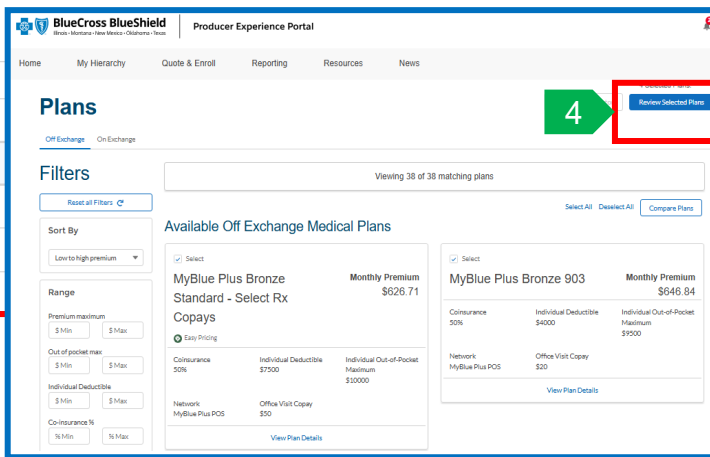
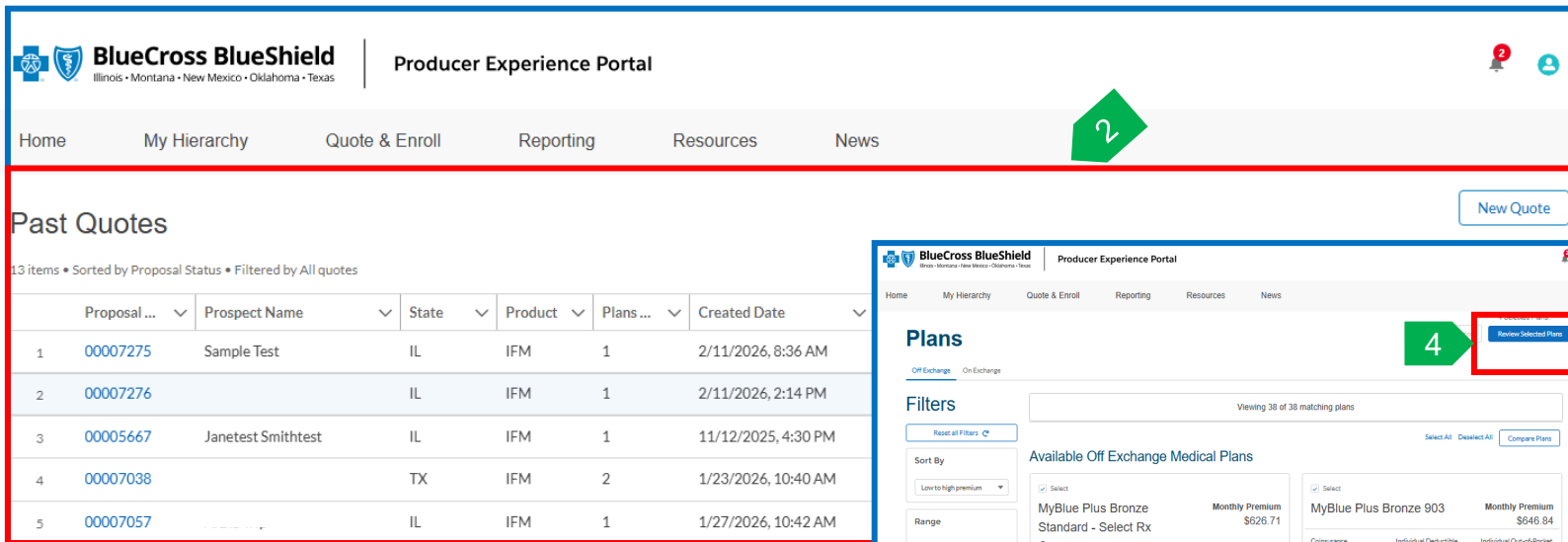
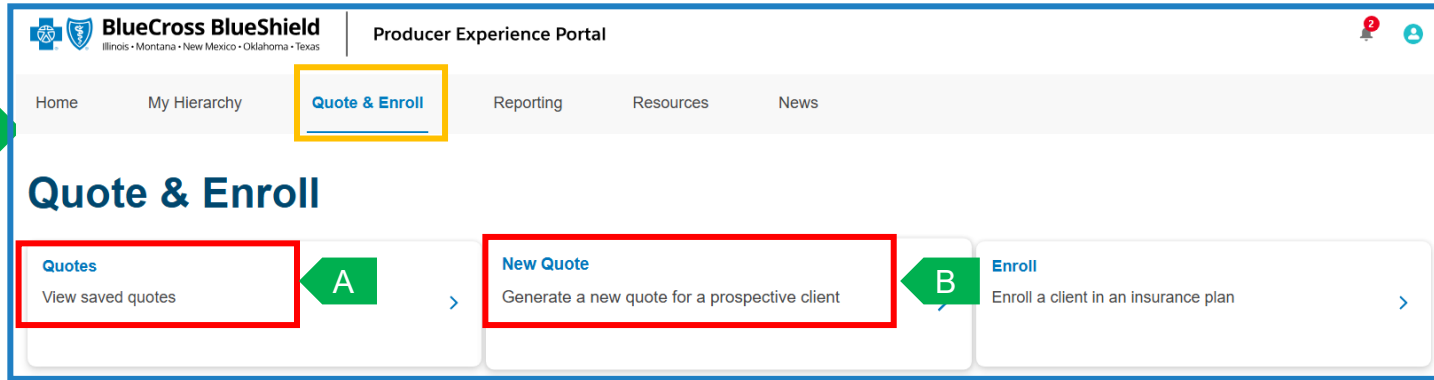
1. Quotes: If saved quote(s) exist
2. New Quote: Create new quote and continue to enrollment
3. Enroll: Start New Application

The screenshot displays the BlueCross BlueShield Producer Experience Portal. The top navigation bar includes the BlueCross BlueShield logo, the text "Producer Experience Portal", and a notification bell icon with a red "2" badge. Below the navigation bar, the "Quote & Enroll" tab is selected and highlighted. The main content area features three large, white, rounded rectangular buttons, each outlined in red and numbered with a green arrow:

- 1 Quotes**: View saved quotes
- 2 New Quote**: Generate a new quote for a prospective client
- 3 Enroll**: Enroll a client in an insurance plan

# Enrollment Via Quotes or New Quotes

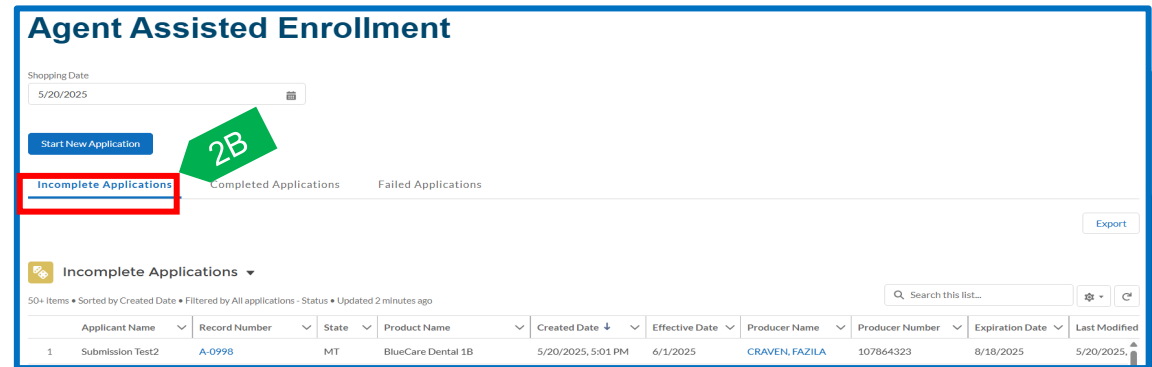
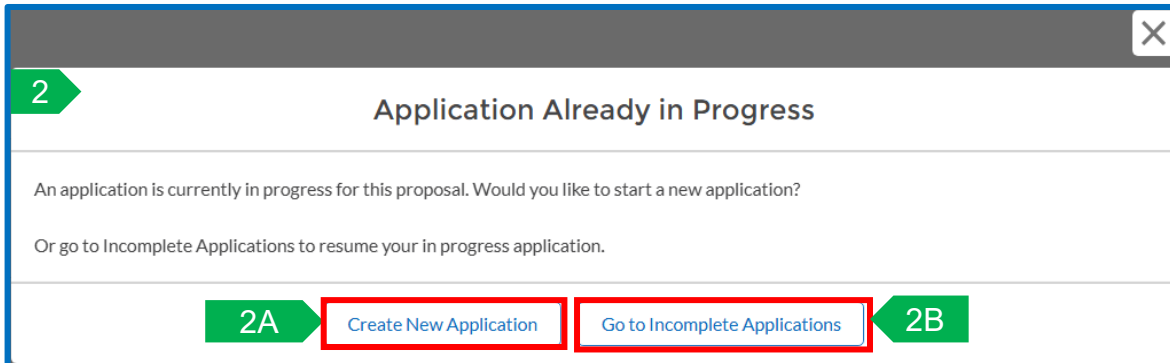
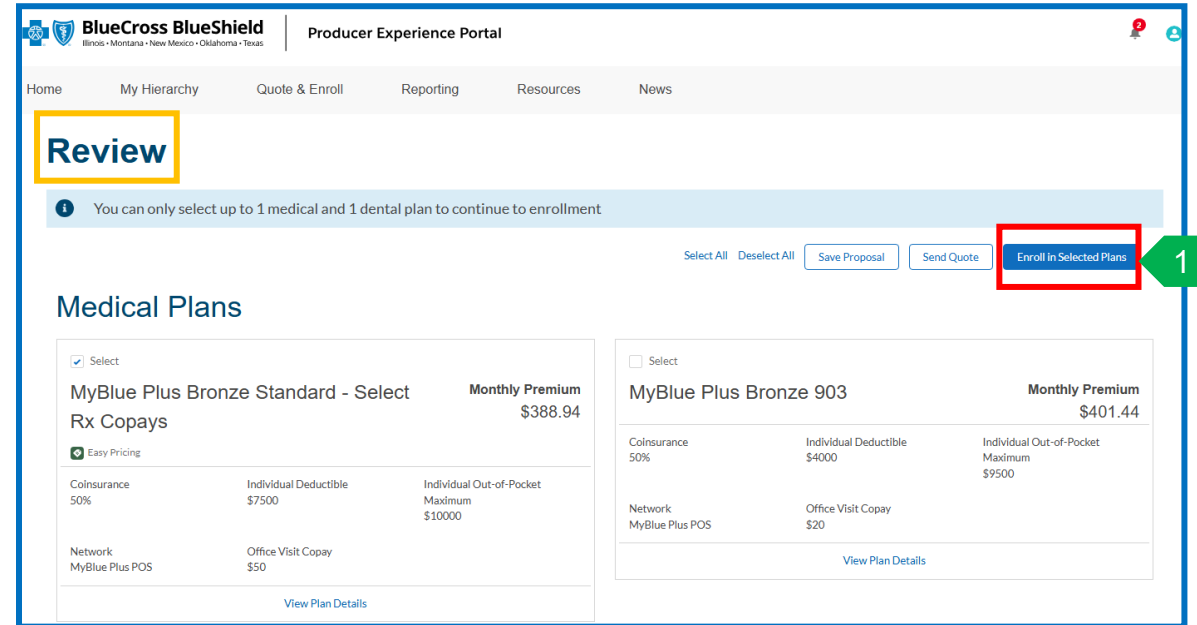
- For enrollment via quotes or new quotes, user will navigate to
  - Quotes** (if saved quotes exist)
  - New Quote** (to create a new quote)
- If the user selects Quotes, choose an **existing quote**.
- If the user selects **New Quotes**, complete the **Primary Applicant Information** page by filling out the required fields and select view plans.
- User will select the desired plan and select **Review Selected Plans** (For quotes or new quotes)



# Enrollment Via Quotes or New Quote

1. On the Review page, once the user has selected only one Medical and/or one Dental plan, they will be able to select **Enroll in Selected Plans** button to begin enrollment.
2. If enrollment has already been started for the quote, the user will receive a pop-up with the following options:
  - A. To start new application, select **Create New Application** button.
  - B. To resume the in-progress application, select **Go To Incomplete Application** button.

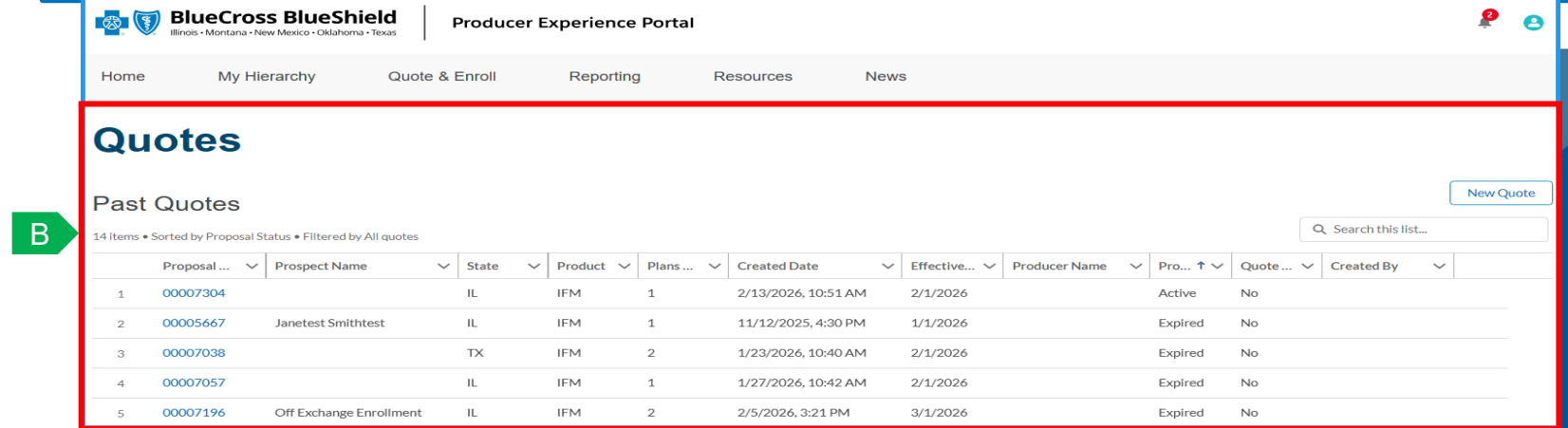
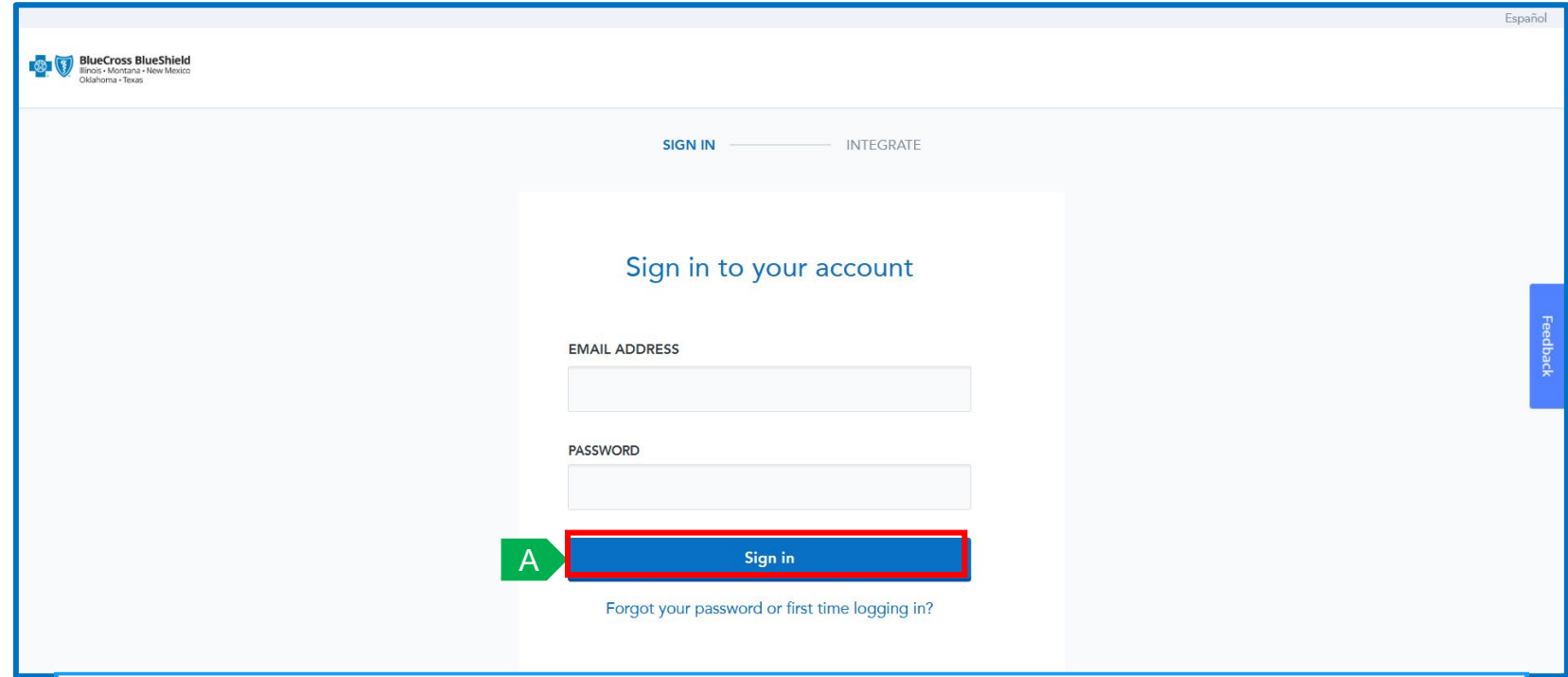
**NOTE:** Please refer to the Quoting User Guide for the quote flow.



# On Exchange Enrollment

1. To enroll in an **On Exchange plan**, select the **Enroll in Selected Plans** button on the Review page. The user will be redirected to the IFM Shopping Platform (ISP) or the State-Based Exchange (SBE), if applicable, in a new tab.
  - A. For states that redirect to **ISP**, the user will land on the **Sign in page**. The user can sign in or register, if they don't have an existing account.
  - B. In the Producer Experience Portal tab, the user will be redirected to the Quote list view page.

**NOTE:** *Delegate Users will not be able to complete On Exchange enrollments*



# Off Exchange Enrollment: From a Quote

## General Info/SEP/Effective Date

If the client wants to enroll in an Off Exchange plan(s), upon selecting **Enroll in Selected Plans** button, the user will be redirected to the Enrollment flow.

1. The enrollment pages will display the General Information section with the following information prepopulated from the quote:

- A. Applicant name
- B. Effective Date
- C. Medical Plan
- D. Dental Plan
- E. Monthly Premium

2. The Producer Information section will be pre-populated with the information provided during quoting.

**NOTE:** *If the Producer Information needs to be updated, then the user will need to start a new quote or new enrollment.*

1. The Special Enrollment Information section will default to Yes and will only be editable during Open Enrollment. To continue with enrollment, user **MUST** do the following:

- 2. Select a **Life Event(s)** and **Date of Event(s)** and then select the **Save** button.
- 3. The user can **edit** the life event by selecting the **Pencil** icon or **delete** the life event by selecting the **X** icon. User can only delete a life event if more than one life event has been added.
- 4. Select **Calculate Effective Date** button to calculate the Effective Date. The effective date will be populated.

# Off Exchange Enrollment: From a Quote

## Authorization/Applicant Information

1. The Application Form will be prepopulated with the plan(s) selection made during quoting. If changes are needed, the user must start a new Quote.
2. The user will select one of the Authorization options. If the user selects the second option, the Terms and Agreements window will display, and the agent must confirm the client has accepted the Terms and Agreements to select the Continue button.

3. The Applicant Information section will be prepopulated with information entered during quoting. The user will need to complete additional required fields and will have the option to update prepopulated fields.

- A. Personal Information
- B. Home Address
- C. Contact Information

### Application Information

Application Form  
Medical/Dental Application

### Authorization

\*Authorization  
 I confirm/attest that my client has completed and signed a paper application, and as the producer of record, I will be completing and submitting the application on their behalf. I will keep a record of the paper application for a minimum of two years from submit date.  
 I confirm/attest that I am assisting my client in person. That all the terms, agreements, acknowledgements and authorizations displayed on paper application have been presented and communicated to my client.

### Applicant Information

Personal Information

\*First Name  MI  \*Last Name   
 \*Date of Birth  SSN   
 \*Within the past six months, have you used tobacco? 4 or more times per week on average, excluding religious or ceremonial uses.  
 Yes  No  
 \*Sex  Male  Female  
 \*Date of last use

### Home Address

\*Address  Apt/Suite   
 \*City  \*State   
 \*Zip Code  \*County   
 \*Is Mailing Address different than Home Address?  
 Yes  No

### Contact Information

\*Primary Phone   
 \*Phone Type  Mobile  Landline  
 Email Address

By providing your mobile phone number on this Application, you agree to receive automated, informational text messages from BCBSIL, including from third-party vendors or providers directly contracted by BCBSIL, to answer questions and provide additional information about health plan products, benefits and programs. You may also set your preferences at [account.bcsil.com/upp/](http://account.bcsil.com/upp/). Standard mobile phone and/or text message charges may apply from your wireless provider. Messages will be recurring. Frequency will vary. Consent is not a condition of purchase or enrollment.

\* If you want to get information from us electronically, we must have your email address. By listing an email address, you agree we may send your policy information electronically, such as policy kits, explanation of benefits and claim letters. This electronic delivery will continue through any policy renewals or changes.  
 You can change to paper delivery at any time with no penalty. To make or change your choices once you are a member, you may:  
 • Update your preferences and contact information at [account.bcsil.com/upp/](http://account.bcsil.com/upp/),  
 OR  
 • Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge or Safari.

**Terms and Agreements**

By clicking "Agree" below, you signify that:

You understand and accept the Blue Cross and Blue Shield of Illinois (BCBSIL) general website Terms of Use and Privacy Statement.  
 Accepting these terms does not obligate you to complete or submit your application for insurance. If you do not understand or accept these terms or the Terms of Use and Privacy Statement, you will not be able to continue with this online application process.

**Acknowledgments**  
 BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE FOLLOWING:

- This Application is not coverage. Coverage will not begin until (1) the effective date of the plan and (2) the first month's payment is made. Some exceptions apply during a Special Enrollment Period. Check with your agent or Customer Service.
- If I am an agent, they cannot accept bids or change the policy or rules of BCBSIL.
- If an agent was helping me purchase an individual or family health or dental plan, BCBSIL may pay the agent a commission and/or other payment. If I want more detail about any payment to the agent, I should ask the agent.
- If any person knowingly submits a false claim for payment of a loss or benefit or falsely misstates an important fact on this Application, coverage may be rescinded. This includes false claims or facts about me or any of my dependents. Rescission sends the claim back to the first day coverage becomes effective. I will be given at least 30 days' written notice before my coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the state's department of insurance and other applicable state and federal laws and regulations. Rates are calculated based on age and geographic rating factors. These factors are also used to calculate premiums for any dependents covered on my policy.
- I authorize any of the following people or organizations to share my health information with BCBSIL or their authorized representative:
  - Health professionals, hospitals, or clinics
  - Other health or health-related facilities
  - Government agencies
  - Pharmacy benefit managers, (health)pharmacies, or retail stores
  - Any other persons or firms required by law
- This information may include:
  - Copies of records about advice, care or treatment that were given to me and/or my dependents
  - Information about the prescription and use of drugs or alcohol
  - Information about mental fitness
- BCBSIL may review and research its own records for information.
- BCBSIL will share collected information only as needed with medical entities to help manage my care.
- Information shared with my authorization may be received by BCBSIL, or shared or required by law. If such sharing is required, the person or agency getting the information will be responsible for protecting it.
- This authorization is valid for two years from today, or until I cancel coverage.
- I have the right to cancel the authorization of any time, in writing, by contacting BCBSIL.
- If I request a substance to represent me will receive a copy of this authorization upon request.
- Any cancellation will not affect the activities of BCBSIL before the date such cancellation is received by BCBSIL.
- I present my statements and answers on this Application as FACTS. To the best of my knowledge and belief, they are true and complete. These facts are the basis of my Application.
- This application will become a part of the contract between BCBSIL and me.
- My agent (if I have one) and I confirm that I have read and understood the application and reviewed the details of the plan I chose.
- The individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as defined in the Application, will pay BCBSIL directly.
- BCBSIL does not accept payments directly from third parties except from those listed in the Third Party Payment Notice section below.
- If those rules are broken, any payments made by a third party will not be credited to my account or coverage. Those payments may not be refunded to me. This may result in the cancellation of my coverage for nonpayment.

**WARNING: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFAULT OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF A HEALTH PLAN CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE FOUND GUILTY OF A FELONY IN A COURT OF LAW.**

**THIRD PARTY PAYMENT RULES:**  
 BCBSIL follows the premium payment process established by the Affordable Care Act in accordance with all federal requirements.

- BCBSIL accepts premium payments from the following third-party entities on behalf of enrollees:
  - Plan within the IVHSIG program under the ACA of the public health service act;
  - An Indian tribe, tribal organization, or urban Indian organization; and
  - A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.
- BCBSIL may accept premium payments on behalf of enrollees from private, not-for-profit foundations, if the payments are:
  - For the entire coverage period of the member's policy;
  - Based solely on the financial status of the enrollee;
  - Regardless of the coverage the enrollee chooses; and
  - Acquisition of the member's health status.
- BCBSIL may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.
- BCBSIL will not continue payments from an employer as long as the employer is responsible for third-party payments, provided such payments do not create an employee retirement (defined contribution) plan, group health plan and other:
  - The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or
  - The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICRHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.
- BCBSIL will accept payments on behalf of an enrollee directly from an employer engaged in an ACA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

**KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE:**  
 If you choose "Yes", above, BCBSIL may NOT automatically cancel your old policy. This section confirms that you plan to cancel your current accident and health plan and replace it with a plan from BCBSIL. For your own information and protection, you should know how this decision may affect the coverage available to you or a new plan.

- You may want to ask the company that offers the plan you are replacing about your decision. You could also talk to your agent. This is your right. It is in your best interest. You should be sure you understand all the issues you may have if you replace the coverage you have now.
- If you still wish to cancel your present plan and replace it with new coverage, be sure to truthfully and completely answer all questions on this Application about any person applying for coverage. If you have not any important information, BCBSIL may have a legal basis to deny any future claims and to refund your premium as though your contract had never been in force. Before you sign the completed Application, read it carefully to be sure that all information is correct.

I agree to the terms and conditions outlined above.

Cancel Continue

# Off Exchange Enrollment: From a Quote

## Language/Ethnicity/Identity/HRA/Spouse/Dependents

1. User can complete following optional sections for the Primary Applicant:  
A. Health Reimbursement Arrangement (**HRA**)  
B. – Please Complete if Applicable  
C. Optional Language, Ethnicity, & Identity

2. User will select the **pencil icon** to complete or edit the Applicant information for a **Spouse** and/or **dependent(s)**.

A. **Spouse** and/or **Dependent(s) Date of Birth (DOB)** and **Sex** will be pre-populated from the original quote and can be edited if needed.

B. The user has option to complete the **Optional Language, Ethnicity, & Identity** section for **Spouse** and/or **Dependent**.

C. The user will select the **Save** button.

**NOTE:** User will need to complete other required fields that are not prepopulated from the original quote.

3. User can remove **Spouse** and/or **Dependent(s)** by selecting **X**.

4. The user will select **Next** button to continue.

**NOTE:** If a spouse and/or dependent(s) was not added during quoting, the user can add them during enrollment by selecting the **+Add Spouse** or **+Add Dependent** button.

**1A** Health Reimbursement Arrangement (HRA) - Please Complete if Applicable

Type of HRA  
 ICHRA  QSEHRA

Start Date  
[Calendar icon]

Employer Name  
[Text input]

Monthly Contribution  
[Text input]

**1B** Optional Language, Ethnicity, & Identity

Preferred Spoken Language  
[Dropdown]

Preferred Written Language  
[Dropdown]

If you are Hispanic/Latino, do you identify as any of the following?

Mexican  
 Cuban  
 Puerto Rican  
 Chicano  
 Mexican American  
 Other

Are you or do you identify as any of the following?

White  
 Black or African American  
 American Indian or Alaskan Native  
 Asian Indian  
 Chinese  
 Filipino  
 Japanese  
 Korean  
 Vietnamese  
 Other Asian  
 Native Hawaiian  
 Guatemalan or Chamorro  
 Samoan  
 Other Pacific Islander  
 Other

**2A** Spouse Information

\*First Name [Text input] MI [Text input] \*Last Name [Text input]

\*Date of Birth [Text input] SSN [Text input]

\*Sex  
 Male  
 Female

Primary Phone: [Text input]

If you want to get information from us electronically, we must have your email address. By listing an email address, you agree we may send your policy information electronically, such as policy kits, explanation of benefits and claim letters. This electronic delivery will continue through any policy renewals or changes. You can change to paper delivery at any time with no penalty. To make or change your choices once you are a member, you may:  
• Update your preferences and contact information at [account.bcbsil.com/appi](#).  
OR  
• Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Chrome, Firefox, Microsoft Edge or Safari.

**2B** Optional Language, Ethnicity, & Identity

Optional Language, Ethnicity, & Identity

Preferred Spoken Language  
[Dropdown]

If you are Hispanic/Latino, do you identify as any of the following?

Mexican  
 Cuban  
 Puerto Rican  
 Chicano  
 Mexican American  
 Other

Are you or do you identify as any of the following?

White  
 Black or African American  
 American Indian or Alaskan Native  
 Asian Indian  
 Chinese  
 Filipino  
 Japanese  
 Korean  
 Vietnamese  
 Other Asian  
 Native Hawaiian  
 Guatemalan or Chamorro  
 Samoan  
 Other Pacific Islander  
 Other

**2** Spouse

Spouse information should be added before proceeding to the next screen.

First Name: -	Last Name: -	DOB: 02/10/1988	<b>2</b> [Pencil icon] [X icon]
Sex: Female	Tobacco Use: No		

**3** Dependents

Dependent information should be added before proceeding to the next screen.

First Name: -	Last Name: -	DOB: 02/04/2026	<b>3</b> [X icon]
Sex: Male			

+ Add Dependent

Cancel Save & Exit **4** Next

**2C** Save

# Off Exchange Enrollment: From a Quote

## Plan Selection/PCP Information

- The user will select the client's desired plan(s).
  - Zip Code (prepopulated)
  - County (prepopulated)
  - Medical Coverage (if applicable)
  - Dental Coverage (if applicable)
  - Medical Coverage Premium (if applicable)
  - Dental Coverage Premium (if applicable)
  - Total Monthly Premium: will update based on plan(s) selected

**NOTE:** The user may change Medical and Dental plans on this step or attest that the client has existing pediatric dental coverage. Changing plan(s) will update Monthly Premium in the General Information section.

- PCP Information section will display only for **HMO** and **POS** plans. The user can enter the Primary Care Provider (PCP) or Medical Group ID for each applicant.
  - For enrollments with multiple applicants, select the **Use Same PCP Number for All** button to apply the PCP ID for all applicants.

**NOTE:** The user can select **Provider Finder** to search for and add a PCP or Medical Group that is in the plan's network.

If a PCP is not selected, BCBS will assign one. The client can change the auto-assigned PCP or Medical Group once they become a member.

- The user will select **Next** button to continue

# Off Exchange Enrollment: From a Quote

## Coverage Replacement, Other Coverage, and Proxy Information

- Coverage Replacement** section will default to **No**. If the user selects **Yes**, they will need to enter the following required fields for each applicant who is replacing coverage, then click the **Save** button:
  - Covered Person**
  - Name of Insurance Company**
  - Policy Number**
  - Termination Date**

User can view **Know Your Rights When You Replace Coverage** by selecting the hyperlink.

**NOTE: Coverage Replacement will not display for Dental Application Forms in some states.**

- Other Coverage You and Your Dependent(s) May Have** section will default to **No**. If the user selects **Yes**, they will need to enter the following required fields for each applicant then click the **Save** button:
  - Applicant Name**
  - Name on Other Policy (if different)**
  - Member Number**
  - Group ID**
- Proxy Information is optional. The User can view the **Proxy Statement** by selecting the hyperlink for Proxy Statement

The screenshot displays the 'Enrollment' page in the BlueCross BlueShield Producer Experience Portal. The page is divided into several sections:

- General Information:** A table showing Applicant Name (Jessica Tester), Effective Date (04/01/2026), Total Monthly Premium (\$1732.50), Medical Plan (MyBlue Plus Bronze 903), and Dental Plan (BlueCare Dental 1A).
- Other Coverage and Proxy Information:** This section contains three sub-sections:
  - Coverage Replacement:** Includes a hyperlink for 'Know Your Rights When You Replace Coverage' and a radio button for 'No' (selected).
  - Other Coverage You or Your Dependent(s) May Have:** Includes a question about existing coverage and a radio button for 'No' (selected).
  - Proxy Information:** Includes an optional checkbox for 'I agree to the Proxy Statement'.
- Know Your Rights When You Replace Coverage:** A detailed informational pop-up window.
- Proxy Statement:** A section for signing a proxy statement, including a 'Proxy Statement' hyperlink.

Annotations on the screenshot include:

- 1:** Points to the 'Know Your Rights When You Replace Coverage' hyperlink.
- 2:** Points to the 'Other Coverage You or Your Dependent(s) May Have' section.
- 3:** Points to the 'Proxy Information' section.
- 1A, 1B, 1C, 1D:** Point to the input fields for Covered Person, Name of Insurance Company, Policy Number, and Termination Date in the 'Coverage Replacement' section.
- 2A, 2B, 2C, 2D:** Point to the input fields for Applicant Name, Name on Other Policy, Member Number, and Group ID in the 'Other Coverage' section.
- 1:** Points to the 'Save' button in the 'Coverage Replacement' section.
- 2:** Points to the 'Save' button in the 'Other Coverage' section.

# Off Exchange Enrollment: From a Quote

## Signatures/Payment

The user will complete following sections of the final step of enrollment.

### 1. Signatures

- A. **Authorized Representative:** If the application is signed by a personal representative on behalf of an individual, check "*I am an authorized representative filling out this application on behalf of the primary applicant.*"
- B. If the application is for **under 18 child only, Parent/Legal Guardian Information** section will be displayed. The user will need to complete the required fields.

**NOTE:** Texas applicants are required to attest to the Consumer Choice Disclosure, except for those enrolling in the Blue Advantage Gold HMO 207 plan.

### 2. Payment Information

- A. **Pay Now:** User will be redirected to Payment Portal upon successfully submitting application.
- B. **Pay Later:** Applicant will receive a bill in mail.

- 3. The user will select **Submit Application.** A payment selection is required before submitting the application.

**Enrollment**

Applicant Name	Effective Date	Medical Plan	Dental Plan	Monthly Premium
Off Exchange Enrollment	05/01/2025	Blue Choice Preferred Gold PPO 204	BlueCare Dental 1C	\$3340.10

**1** Signatures

**1 Note** Consumer Choice Disclosure

**1A** Authorized Representative

**2** Payment Information

**2A** Pay Now / Pay Later

**3** Submit Application

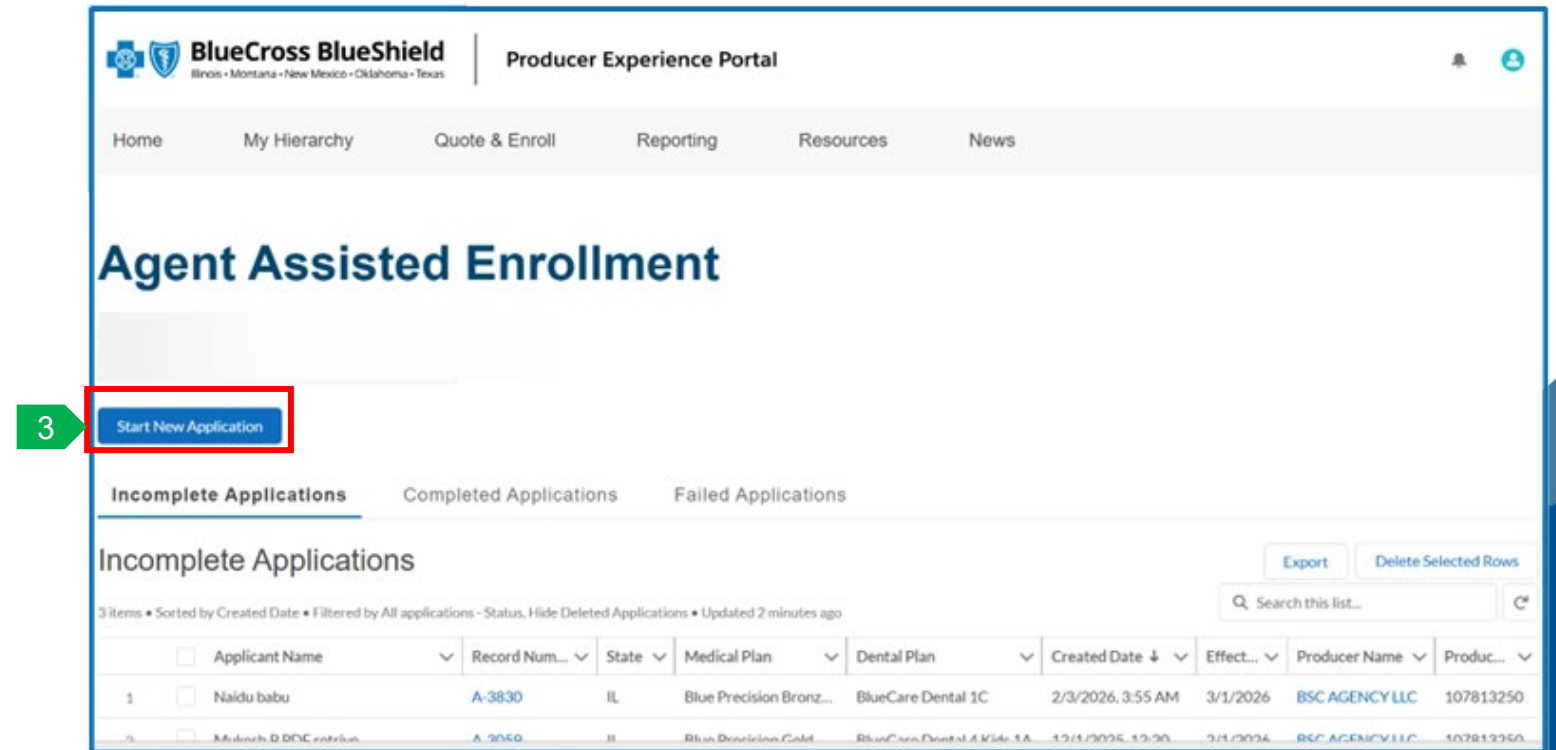
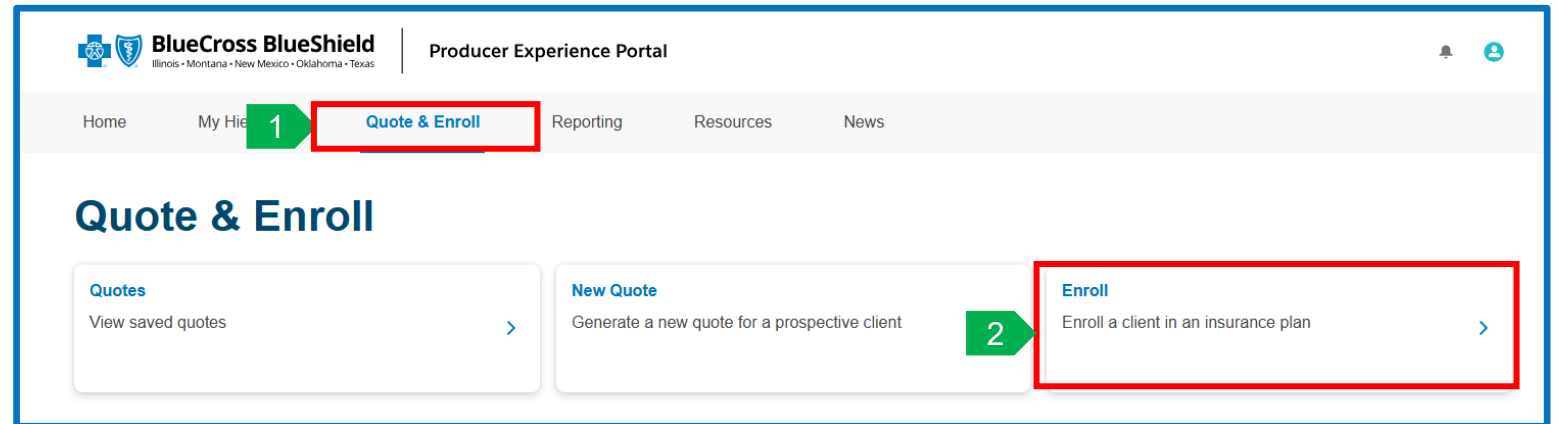
**1B** Parent/Legal Guardian Information

**1A** Authorized Representative

# New Enrollment: Start New Application

## Start New Application

1. Select **Quote & Enroll** Tab.
2. Select **Enroll** On the Agent Assisted Enrollment page.
3. User will select **Start New Application** button to begin a new Off Exchange application.



# New Enrollment (Producer View)

## General Info/SEP/Effective Date

1. On the **Enrollment Page**, under **Producer Information** section, the user will select the state that matches the client's Home Address. Producer Name, Writing Producer Number, and Company Name will auto-populate once the state is selected.

**NOTE:** If producer has multiple Producer IDs for any state, they will see that state multiple times in the State dropdown. Producer will need to view each one to find and select the correct producer id.

2. The **Special Enrollment Information** section will default to **Yes** and will only be editable during **Open Enrollment**. To continue with enrollment, user **MUST** do the following:
  - A. Select a **Life Event(s)** and **Date of Event(s)** and then select the **Save** button.
  - B. The user can **edit** the life event by selecting the **Pencil** icon or **delete** the life event by selecting the **X** icon. User can only delete a life event if more than one life event has been added.
  - C. Select **Calculate Effective Date** button to calculate the Effective Date. The effective date will be populated.

The screenshot shows the 'Enrollment' form with several sections highlighted by red boxes and numbered callouts:

- 1:** Points to the 'Producer Information' section, which includes a dropdown for 'State' (IL), a text field for 'Writing Producer Number' (220002580), and text fields for 'Producer Name' (FRITZ, CALVIN C) and 'Company Name' (FRITZ, CALVIN C).
- 2:** Points to the 'Special Enrollment Information' section, which has a radio button for 'Yes' selected under the question 'Is this a Special Enrollment Period or "SEP" Application?'.
- 2A:** Points to the 'Add Life Event' button in the 'Special Enrollment Information' section.
- 2B:** Points to the edit (pencil) and delete (X) icons for a life event entry.
- 2C:** Points to the 'Calculate Effective Date' button in the bottom section of the form.

The top section, 'General Information', shows 'Applicant Name', 'Effective Date' (03/02/2026), and 'Total Monthly Premium' (-). Below it, 'Medical Plan' and 'Dental Plan' are both listed as '-'. The bottom section shows the 'Effective Date' (03/02/2026) after calculation.

This is a close-up of the 'Life Event' selection form. It features a dropdown menu for '\* Life Event' and a date picker for '\* Date of Event'. Below the dropdown is the text: 'If you do not see your circumstance listed above, please contact our Pre-Sales Support team'. At the bottom, there are 'Cancel' and 'Save' buttons. A callout '2A' points to the 'Save' button.

# New Enrollment (Delegate View)

## General Info/SEP/Effective Date

1. On the **Enrollment Page**, under **Producer Information** section, the user will start typing **Writing Producer Number** and select from the drop down. Writing Producer Number and Home Address State must match.

**NOTE:** *Producer Name, Company Name, and State will auto-populate once the Writing Producer Number is selected.*

2. The **Special Enrollment Information** section will default to **Yes** and will only be editable during **Open Enrollment**. To continue with enrollment, user **MUST** do the following:
  - A. Select a **Life Event(s)** and **Date of Event(s)** and then select the **Save** button.
  - B. The user can **edit** the life event by selecting the **Pencil** icon or **delete** the life event by selecting the **X** icon. User can only delete a life event if more than one life event has been added.
  - C. Select **Calculate Effective Date** button to calculate the Effective Date. The effective date will be populated.

2A

# New Enrollment: Authorization/Applicant Information

## Authorization/Applicant Information

- From the **Application Form Type** dropdown, user will select from the following options:
  - Mental/Dental Application
  - Dental Application
- The user will select one of the **Authorization** options. If the user selects the second authorization option, the Terms and Agreements window will display, and the agent must confirm the client has accepted the Terms and Agreements to select the **Continue** button.
- Under **Applicant Information** section, user will enter the applicant's personal information:
  - Use the Client Search field to locate an existing client. The system will automatically prepopulate the applicant's information, **OR**
  - Enter the Applicant's information manually (First Name, Last Name, Date of Birth, SSN, Sex).

**NOTE:** If an existing client is selected, the prepopulated applicant information can be edited if updates are needed.

The screenshot displays the BlueCross BlueShield Producer Experience Portal. The main content area is divided into three sections: **Application Information**, **Authorization**, and **Applicant Information**. A **Terms and Agreements** window is open on the right side. Green callout boxes indicate the following steps:

- 1:** Points to the **Application Form Type** dropdown menu.
- 1A:** Points to the **Medical/Dental Application** option in the dropdown.
- 1B:** Points to the **Dental Application** option in the dropdown.
- 2:** Points to the **Authorization** section, which contains two radio button options for confirming the application process.
- 3:** Points to the **Applicant Information** section, which includes a **Client Search** field and a **Personal Information** section with fields for First Name, MI, Last Name, Date of Birth, SSN, and Sex.
- 3A:** Points to the **Client Search** input field.
- 3B:** Points to the **Personal Information** input fields.

The **Terms and Agreements** window on the right contains the following text:

By clicking "I Agree" below, you signify that:

You understand and accept the Blue Cross and Blue Shield of Illinois (BCBSIL) general website Terms of Use and Privacy Statement.

Accepting these terms does not obligate you to complete or submit your application for insurance. If you do not understand or accept these terms or the Terms of Use and Privacy Statement, you will not be able to continue with this online application process.

- Based solely on the financial status of the enrollee;
- Regardless of the coverage the enrollee chooses; and
- Regardless of the enrollee's health status.

3. BCBSIL may accept premium payments on behalf of enrollees from a Trust, Power of Attorney or Legal Guardian.

4. BCBSIL will not construe payments from an employer as impermissible third-party payments, provided such payments do not create an Employee Retirement Income Security Act (ERISA) group health plan and either:

- The employer facilitates premium payment collection through payroll deduction or a similar method for the employee, and the employer is not paying any part of the premium either directly or through reimbursement; or
- The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer in place of group health insurance.

5. BCBSIL will accept payments on behalf of an enrollee directly from an employer engaged in an ICHRA or QSEHRA, or a third-party payment coordination service, when such payments are made using allowable payment methods.

I agree to the terms and conditions outlined above

Cancel Continue

# New Enrollment: Authorization/Applicant Information

## Authorization/Applicant Information

4. The user will enter the Applicant's **Home Address information**.
  - A. Use the Address Search field to search. Once the user starts typing, the system will automatically populate the Applicant's Home Address, **OR**
  - B. Enter the Applicant's Home Address manually (Address, Apt/Suite, City, State, Zip Code, County).
  
5. The user will enter Applicant's Contact Information (*Primary Phone, Phone Type, Email Address*).

**NOTE:** *If the Mailing Address is different than the Home Address, user can enter that mailing address.*

The screenshot shows a web form for entering applicant information. It is divided into three main sections:

- Home Address:** Contains an "Address Search" field with a search icon. Below it is a checkbox for "Enter in address manually". If checked, there are input fields for "Address", "Apt/Suite", "City", "State", "Zip Code", and "County".
- Contact Information:** Contains a required field for "Primary Phone" and a "Phone Type" section with radio buttons for "Mobile" and "Landline". Below this is a paragraph of text regarding consent for automated text messages and a required "Email Address" field.
- Disclaimer:** A paragraph explaining that by providing an email address, the user agrees to receive electronic policy information. It also provides instructions on how to change delivery preferences (via [mybam.bcsil.com](http://mybam.bcsil.com) or by calling customer service).

Callouts on the left side of the form:

- 4A:** Points to the "Address Search" field.
- 4B:** Points to the "Enter in address manually" checkbox.
- 5:** Points to the "Primary Phone" field.

# New Enrollment: Language/Ethnicity/Identity

## Language/Ethnicity/Identity /HRA/Spouse

1. The user can complete following optional sections for the Primary Applicant:  
A. Health Reimbursement Arrangement (**HRA**) – Please Complete if Applicable  
B. Optional Language, Ethnicity, & Identity

2. The user can select **+ Add Spouse** to enter Spouse information

**NOTE:** The user has option to complete the *Optional Language, Ethnicity, & Identity* section for Spouse and/or Dependent(s).

3. The user will click **Save**

The screenshot shows a multi-step enrollment form. The top section is for the Health Reimbursement Arrangement (HRA), with a red box and callout '1A' pointing to the 'Type of HRA' radio buttons (ICHRA, QSEHRA). Below this is the 'Optional Language, Ethnicity, & Identity' section, with a red box and callout '1B' pointing to its header. A central 'Spouse' section contains a '+ Add Spouse' button, with a red box and callout '2'. To the right, the 'Spouse Information' form is visible, with a red box and callout '2' pointing to its fields (First Name, MI, Last Name, Date of Birth, SSN, Sex). A 'Note' callout points to the 'Optional Language, Ethnicity, & Identity' section. At the bottom right, a 'Save' button is highlighted with a red box and callout '3'. A yellow box highlights another 'Save' button at the bottom right of the page.

# New Enrollment: Language/Ethnicity/Identity

## Language/Ethnicity/Identity/HRA/Dependents

4. The user can select **+ Add Dependent** to enter the Dependent information(s).

**NOTE:** Up to 19 dependents, including spouse, can be added.

The user has option to complete the Optional Language, Ethnicity, & Identity section for Spouse and/or Dependent(s).

5. The user will click **Save**

6. The user will select **Next** button to continue

Dependents  
Dependent Information should be added before proceeding to the next screen.

4 →

6 →

4 →

Dependent Information

\* First Name  MI  \* Last Name

\* Date of Birth  SSN

\* Sex  
 Male  
 Female

Note →

5 →

✓ Optional Language, Ethnicity, & Identity

Preferred Spoken Language

If you are Hispanic/Latino, do you identify as any of the following?

- Mexican
- Cuban
- Puerto Rican
- Chicano
- Mexican American
- Other

Are you or do you identify as any of the following?

- White
- Black or African American
- American Indian or Alaskan Native
- Asian Indian
- Chinese
- Filipino
- Japanese
- Korean
- Vietnamese
- Other Asian
- Native Hawaiian
- Guatemalan or Chamorro
- Samoan
- Other Pacific Islander
- Other

# New Enrollment: Plan Selection/ PCP Information

## Plan Selection/PCP Information

- The user will select the client's desired plan(s).
  - Zip Code (prepopulated)
  - County (prepopulated)
  - Medical Coverage (if applicable)
  - Dental Coverage (if applicable)
  - Medical Coverage Premium (if applicable)
  - Dental Coverage Premium (if applicable)
  - Total Monthly Premium: will updated based on plan(s) selected

**NOTE:** The user will select a Medical and Dental plan on this step or attest that the client has existing pediatric dental coverage. Changing plan(s) will update Monthly Premium in the General Information section.

- PCP Information section will display only for **HMO** and **POS** plans. The user can enter the Primary Care Provider (PCP) or Medical Group ID for each applicant.
  - For enrollments with multiple applicants, select the **Use Same PCP Number for All** button to apply the PCP ID for all applicants.

**NOTE:** The user can select **Provider Finder** to search for and add a PCP or Medical Group that is in the plan's network. Tip: the PCP ID can be copied from the Provider Finder screen and pasted into this field – this will ensure accuracy.

If a PCP is not selected, BCBS will assign one. The client can change the auto-assigned PCP or Medical Group once they become a member.

- The user will select **Next** button to continue

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### Enrollment

**General Information**

Applicant Name	Effective Date	Total Monthly Premium
	01/10/2026	\$901.66
Medical Plan	Dental Plan	
Blue Precision Silver HMO Standard - Select Rx Copays	BlueCare Dental 1D	

**Plan Selection**

Monthly Premium will display once plan(s) have been selected

I/we already have coverage for pediatric dental essential health benefits through another policy.

Zip Code: 60601 County: Cook County

\*Select Medical Coverage: Blue Precision Silver HMO : Select Dental Coverage: BlueCare Dental 1D

Medical Coverage Premium: \$886.79  
 Dental Coverage Premium: \$14.87  
 Total Monthly Premium: \$901.66

**PCP Information**

Primary  
 Medical Group Number (3 Digits): [Input Field]

Spouse  
 Medical Group Number (3 Digits): [Input Field]

Buttons: Cancel, Save & Exit, Previous, Next

**Callouts:**  
 1: Points to Plan Selection section.  
 1. Note: Points to checkbox for existing pediatric dental coverage.  
 2: Points to PCP Information section.  
 2A: Points to 'Use Same PCP Number for All' button.  
 2. Note: Points to 'Provider Finder' button.  
 3: Points to 'Next' button.

# New Enrollment: Proxy/Coverage Replacement/Other Coverage

1. **Coverage Replacement** section will default to **No**. If the user selects **Yes**, they will need to enter the following required fields for each applicant who is replacing coverage, then click the **Save** button:

- A. Covered Person
- B. Name of Insurance Company
- C. Policy Number
- D. Termination Date

User can view **Know Your Rights When You Replace Coverage** by selecting the hyperlink.

**NOTE: Coverage Replacement will not display for Dental Application Forms in some states.**

2. **Other Coverage You and Your Dependent(s) May Have** section will default to **No**. If the user selects **Yes**, they will need to enter the following required fields for each applicant then click the **Save** button:

- A. Applicant Name
- B. Name on Other Policy (if different)
- C. Member Number
- D. Group ID

3. Proxy Information is optional. The User can view **Proxy statement** by selecting the hyperlink for Proxy Statement.

The image displays three screenshots of a web application interface, illustrating the steps for Coverage Replacement, Other Coverage, and Proxy Information.

**Top Left Screenshot: General Information and Other Coverage and Proxy Information**

General Information		
Applicant Name	Effective Date	Total Monthly Premium
	01/10/2026	\$1834.61
Medical Plan	Dental Plan	
Blue Precision Silver HMO Standard - Select Rx Copays	BlueCare Dental 1D	

**Other Coverage and Proxy Information**

**Coverage Replacement**

[Know Your Rights When You Replace Coverage](#)

Will this plan replace health coverage you already have?

Yes  No

**Other Coverage You or Your Dependent(s) May Have**

Does any person applying for coverage currently have, or did they previously have within the last 60 days:

- Coverage with BCBSIL?
- Health coverage with any other insurance company?
- Coverage under a tax-supported or government program, including Medicare?

Yes  No

**Proxy Information**

I agree to the Proxy Statement (optional)

**Bottom Left Screenshot: Other Coverage You and Your Dependent(s) May Have**

\* Covered Person  **1A**

\* Name of Insurance Company  **1B**

\* Policy Number  **1C**

\* Termination Date  **1D**

Cancel **1** Save

**Bottom Right Screenshot: Proxy Statement**

\* Applicant Name  **2A**

\* Name on Other Policy (if different)  **2B**

\* Member Number  **2C**

\* Group ID  **2D**

Cancel **2** Save

# New Enrollment: Signature/Payment

## Signatures/Payment

The user will complete following sections of the final step of enrollment.

### 1. Signatures

- A. **Authorized Representative:** If the application is signed by a personal representative on behalf of an individual, check “*I am an authorized representative filling out this application on behalf of the primary applicant.*”
- B. If the application is for **under 18 child only**, **Parent/Legal Guardian Information** section will be displayed. The user will need to complete the required fields.

**NOTE:** Texas applicants are required to attest to the Consumer Choice Disclosure, except for those enrolling in the Blue Advantage Gold HMO 207 plan.

### 1. Payment Information

- A. **Pay Now:** User will be redirected to Payment Portal upon submitting application
- B. **Pay Later:** Applicant will receive a bill in mail.

- 1. The user will select **Submit Application**. A payment selection is required before submitting the application.

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### Enrollment

General Information				
Applicant Name	Effective Date	Medical Plan	Dental Plan	Monthly Premium
Off Exchange Enrollment	05/01/2025	Blue Choice Preferred Gold PPO 204	BlueCare Dental 1C	\$3340.10

#### 1 Signatures

**Consumer Choice Disclosure**

I agree to the [Consumer Choice Disclosure](#)\* **1 NOTE**  
 Please attest to Consumer Choice Disclosure before submitting application.

**1A Authorized Representative**

If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the following:

I am an authorized representative filling out this application on behalf of the primary applicant

**2 Payment Information**

Payment will occur after the application has been submitted

Pay Now  Pay Later **2A** **2B**

Cancel Save & Exit Previous **3** Submit Application

I am an authorized representative filling out this application on behalf of the primary applicant **1A**

\* First Name  MI  \* Last Name

\* Relationship to Applicant

**1B Signatures**

**Parent/Legal Guardian Information**

\* First Name  MI  \* Last Name

\* Relationship to Applicant

**Authorized Representative**

If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the following:

I am an authorized representative filling out this application on behalf of the primary applicant

# Make a Payment: Capture Payment

## Capture Payment

1. If **Pay Now** option is selected, when user selects **Submit Application** button, they will be redirected to the **Payment Portal** in a new tab.
2. The user will be required to select **Payment Method** and enter **Payment Details**
3. The user will check the **Term of Use and Privacy Statement** Box.

**NOTE:** Autopay is only available with Bank Account. Applicant can pay the initial binder payment with a Credit Card and add Bank details to setup Autopay.

BlueCross BlueShield of Illinois

Español | Language Assistance

Make a Payment

Current Balance  
**\$2,091.40**

**Payment Information**  
Payment will occur after the application has been submitted  
 Pay Now  Pay Later

**Enter payment information**  
To begin your coverage, payment of your first monthly premium is required. Please enter your payment details below. Your payment will not process until your application has completed processing.

**Payment Amount**  
 Current Balance : \$2,091.40  
Amount displayed may be less than required for policy issuance if retroactive effective date.

**Payment Date**  
05 / 01 / 2025

**Payment Method**  
Select payment method  
Select payment method  
New Bank Account  
New Card

I understand and accept the Terms of Use and Privacy Statement.

Review Payment Details

Cancel

# Make a Payment: Submit Payment

## Submit Payment and Redirection to Application Details

1. User should Review Payment Details and select one of the following buttons:

A. **Submit Payment and Proceed:** User must select the checkbox for payment agreement before selecting Submit Payment and Proceed button.

**NOTE:** Although the Payment Confirmation Number is available, the payment has not been completed until the user has selected the "Submit Payment and Proceed" button.

B. **Cancel:** Select this option if the client is not ready to make payment; the client will be billed later.

**NOTE:** This does NOT cancel the client's application.

2. After the payment has been submitted, the user will be redirected back to the **Application Details** page of the Producer Experience Portal and can view the Payment Status.

The image shows two screenshots from the BlueCross BlueShield of Texas website. The top screenshot is the 'Review Payment Details' page, and the bottom screenshot is the 'Application Details' page. Callouts with numbers 1, 1A, 1B, and 2 point to specific elements on both pages.

**1** Review Payment Details

**1B** Are you sure you want to cancel?  
You will lose any information entered.  
No, Don't Cancel Yes, Cancel

**1A**  I agree payments may be taken from the payment method listed above. I also agree to receive emails about my payments.

**1A** Submit Payment and Proceed

**1B** Cancel

**2** Application Details

Application A-0638

Status	Submitted	State	TX
Producer Name	CRAVEN, FAZILA	Date Submitted	5/23/2025
107864325		Record Number	A-0638
\$1,458.81			
Applicant Name			
Off Exchange Enrollment			
Product Name	MyBlue Health Bronze Standard, BlueCare Dental 1A		
Client App ID	1243		
Payment Status	Successful		

View Application PDF

# Application Details

1. When an application is submitted successfully, the user will be redirected to the **Application Details** page.
2. The user can view details and can download the completed application PDF by selecting the **View Application PDF** button.

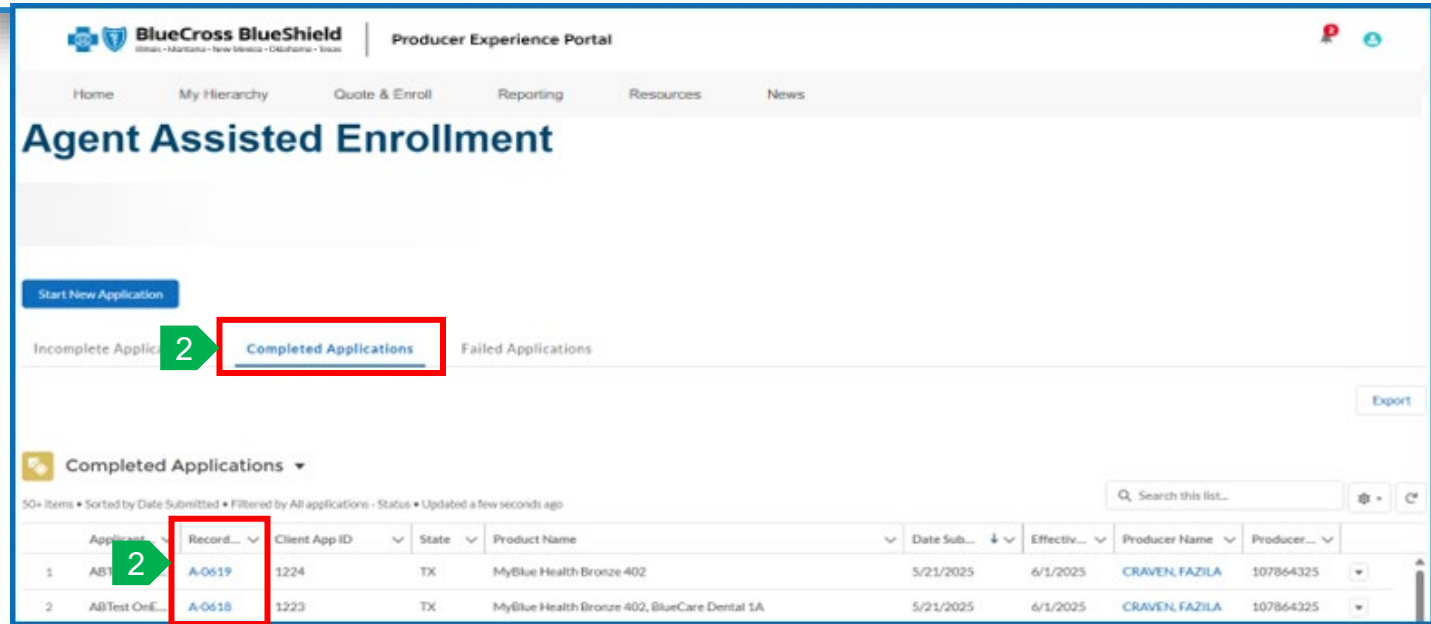
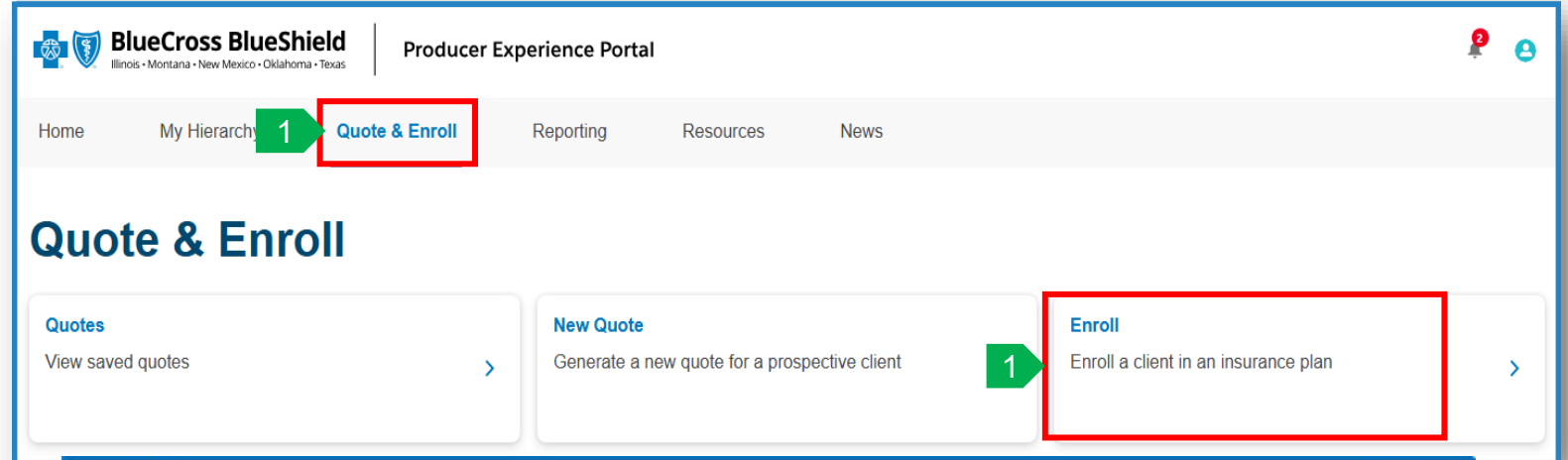
The screenshot shows the 'Application Details' page. A red box highlights the title 'Application Details' at the top. A green arrow labeled '1' points to the application icon and ID 'Application A-0638'. Another green arrow labeled '2' points to the 'View Application PDF' button in the top right corner. A larger red box highlights the main details section, which contains a table of application information.

Status	Submitted	State	TX
Producer Name		Date Submitted	5/23/2025
Producer Number		Record Number	A-0638
Monthly Premium	\$1,458.81		
Applicant Name	Off Exchange Enrollment		
Product Name	MyBlue Health Bronze Standard, BlueCare Dental 1A		
Client App ID	1243		
Payment Status	Successful		

# Completed Applications: List View

## Completed Applications List View

1. The user can navigate to Application Details by selecting **Quote & Enroll** tab then select **Enroll** tile.
2. The User will select **Completed Application** tab then select hyperlink for the Application under **Record Number** column to see the application details.

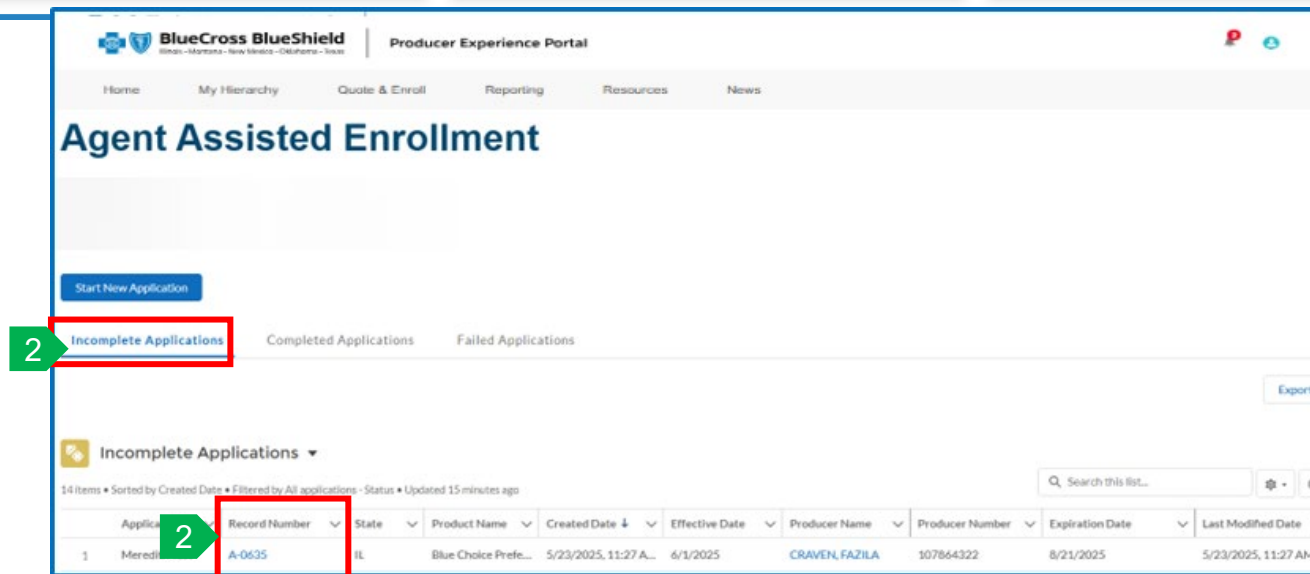
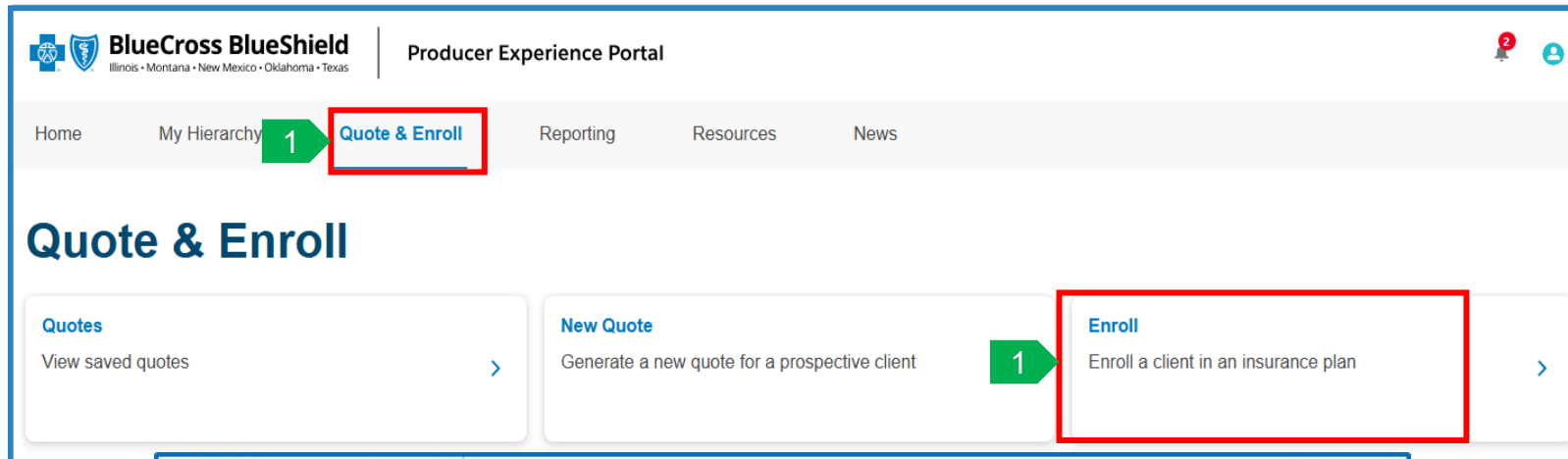


# Saved Applications: List View

## Incomplete Applications List View

The user can Save & Exit an application on any of the enrollment steps. User can navigate to Incomplete Applications by following these steps:

1. Select **Quote & Enroll** tab then select **Enroll** tile.
2. The User will select **Incomplete Applications** tab then select hyperlink for the Application under **Record Number** column to see the application details.



# Failed Applications: List View

## Failed Applications List View

1. If an application fails submission, the user will see Submission Failed message with following two buttons:  
A. **Return to Application**  
B. **Proceed to Failed Applications**
2. The User will select **Failed Application** tab then select hyperlink for the Application under **Record Number** column to see the application details.

**NOTE:** Selecting **Return to Application** button will take the user back to previous page.

For help with questions about failed applications, call 866-446-4353.

The image displays two screenshots of the Producer Experience Portal. The top screenshot shows the 'Enrollment' page with a 'Submission Failed' message and two buttons: 'Return to Application' (labeled 1A) and 'Proceed to Failed Applications' (labeled 1B). The bottom screenshot shows the 'Agent Assisted Enrollment' page with a 'Failed Applications' tab selected (labeled 2) and a table of failed applications. The table has columns for Application, Record Number, Client App ID, State, Date Submitted, Effective Date, Producer Name, Producer Number, Expiration Date, and Last Modified Date. A red box highlights the 'Record Number' column, and a green arrow labeled 2 points to the first row's record number 'A-0616'.

App	Record Number	Client App ID	State	Date Submitted	Effective Date	Producer Name	Producer Number	Expiration Date	Last Modified Date
1	A-0616	1221	TX	5/21/2025	6/1/2025	CRAVEN, FAZILA	107864325	8/19/2025	5/21/2025, 9:24 AM