BlueCross BlueShield of Illinois

FORT DEARBORN LIFE Insurance Company®

Registered Marks of Fort Dearborn Life Insurance Company

APPLICATION AND POLICY CHANGE

① **ENROLLEE:** **New Enrollment:** ☐ Timely ☐ Special ☐ Late | **Open Enrollment:** ☐ New Member Add/Remove Dependents No Change

② **EFFECTIVE DATE:** **Group Number:** **Section Number:** **Identification Number:**

③ **COBRA / Illinois Continuation Section** **Employee Status:** ☒ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___

☐ **COBRA:** Start Date ___/___/___ Projected End Date ___/___/___ | ☐ **IL Continuation Privilege:** Start Date ___/___/___ Projected End Date ___/___/___

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.)
☐ 2. Spouse (divorce from employee, death of employee, other.)
☐ 3. Dependent (reach age limit, married, no longer full-time student, other.)
☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ **COVERAGE APPLIED FOR: Check all that apply.****

⑤ **CHANGES TO EXISTING MEMBERSHIP: Check all that apply.**

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

Medical

☐ Traditional ☐ HMO Illinois ☐ w/HCA (BlueEdge HMO) ☐ BlueAdvantage HMO ☐ w/HCA (BlueEdge HMO) ☐ BlueEdge HSA ☐ Integrated with BCBSIL Vendor ☐ Non-integrated

☐ PPO ☐ BlueEdge HCA ☐ Blue*Choice* Select ☐ BlueEdge Select HSA ☐ Integrated with BCBSIL Vendor ☐ Non-integrated ☐ BlueEdge Select HCA ☐ BlueDecision PPO

☐ PPO Value Choice ☐ CPO ☐ CPO Value Choice ☐ Vision ☐ Hearing ☐ Medicare Supplement

Dental (Optional) None

☐ Individual / Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Enter Dental Group number if different than Medical Group policy number.

☒ Dental Group #:

☒ BlueCare Dental PPO

☐ BlueCare Dental HMO (Select your dental office in section 6 and 7 when applicable)

Fort Dearborn Life Group #: ____________________

Previous BC (Illinois) or HMO Membership:

Group #: ____________ Section #: ____________

Identification #: ____________________

CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
Date: / /	Date: / /	Date: / /	Date: / /
☐ HMO Medical Group/IPA ☐ PCP and/or WPHCP ☐ Name ☐ Address ☐ Telephone ☐ Reinstate ☐ From PPO to HMO ☐ From HMO to PPO ☐ From HMOI to BA HMO ☐ From BA HMO to HMOI ☐ Medicare Coverage ☐ FDL Beneficiary	☐ Marriage ☐ Newborn ☐ Adoption/Placement ☐ Legal Guardianship ☐ Other: Special Enrollment	☐ Marriage ☐ Divorce ☐ Age Limit ☐ Other: Special Enrollment	☐ Terminate Coverage ☐ Waive Coverage** ☐ Leave/Layoff ☐ Out of Service Area Move ☐ Other: Special Enrollment

NOTE: Only list dependents to be added or dropped in the Family Coverage Information Section ⑦.

After checking the appropriate physician change, circle reason:

☐ PCP ☐ WPHCP

A. Availability B. PCP moved office
C. Location D. PCP added to Network
E. Dissatisfied with PCP F. PCP office/facility undesirable
G. Staff H. Other ____________

**If not electing coverage, please read, complete and sign Section ⑪.

⑥ **EMPLOYEE INFORMATION:** Company Name: Lansing School District 158

Last Name: | First Name: | Mid. Initial | E-Mail Address:

Street Address: | Apt. No.: | City: | State: | Zip:

Date of Birth: _____/_____/_____ Are You Eligible for Family Coverage: ☐ No ☐ Yes Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: ________ — ________ — ____________ Employee Identification Number (if known): ____________

Telephone No.: Bus.: (______) ____________ Home: (______) ____________ Date of Hire: ______ / ______ / ______

Dept. No.: ____________ Payroll Location: ____________ Employee Clock No.: ____________

If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Medical Group/IPA Name: ____________

PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: ____________ WPHCP Medical Group/IPA#: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

WPHCP Medical Group Name: ____________ WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ____________

The PCP and WPHCP must have a referral arrangement.

If CPO/CPO Value Choice: Network # CO: ____________ If BlueCare Dental HMO: Office ID#: ____________

Employment Status: ☒ **Actively at Work** ☐ **Retired** **If retired, retirement date:**____________ ☐ **COBRA/IL Continuation**

Are you covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below <u>must</u> be completed:**

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.**

⑦ Ⓐ **SPOUSE:** Date of Birth: _____/_____/_____ Last Name (Only If Different): ____________

First Name: ____________ Social Security Number: ________ — ________ — ____________

If HMO: Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ Medical Group/IPA Name: ____________ WPHCP Medical Group/IPA #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

PCP #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ PCP Name: ____________ WPHCP Medical Group Name: ____________

WPHCP (Physician) #: ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ WPHCP (Physician) Name: ____________ **If BlueCare Dental HMO: Office ID#:**____________

The PCP and WPHCP must have a referral arrangement.

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes** **If Yes, the section below <u>must</u> be completed:**

HIC #: ____________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____ / ____ / ____	Start Date: ____ / ____ / ____	Start Date: ____ / ____ / ____
Start Date: ____ / ____ / ____	End Date: ____ / ____ / ____	End Date: ____ / ____ / ____	End Date: ____ / ____ / ____

BlueCross BlueShield of Illinois

FORT DEARBORN LIFE *Insurance Company*®

Registered Marks of Fort Dearborn Life Insurance Company

EMPLOYEE AND DEPENDENT INFORMATION: Company Name: Lansing School District 158 Group #:

Employee Last Name: Employee First Name: Mid. Initial

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ Ⓑ ☐ **SON** ☐ **DAUGHTER:** Date of Birth: _____/_____/_____ Last Name (Only If Different): ______________ First Name: ______________

Social Security Number: __________ — __________ — __________ **If HMO:** Medical Group/IPA #: ___

Medical Group/IPA Name: PCP #: ___ PCP Name: ______ WPHCP Medical Group/IPA #: ___

WPHCP Medical Group Name: ______ WPHCP (Physician) #: ___ WPHCP (Physician) Name: ______

The PCP and WPHCP must have a referral arrangement.

If BlueCare Dental HMO: Office ID#: ______

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes If Yes, the section below <u>must</u> be completed:**

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: PCP #: ___ PCP Name: ______ WPHCP Medical Group/IPA #: ___

WPHCP Medical Group Name: ______ WPHCP (Physician) #: ___ WPHCP (Physician) Name: ______

The PCP and WPHCP must have a referral arrangement.

If BlueCare Dental HMO: Office ID#: ______

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes If Yes, the section below <u>must</u> be completed:**

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: PCP #: ___ PCP Name: ______ WPHCP Medical Group/IPA #: ___

WPHCP Medical Group Name: ______ WPHCP (Physician) #: ___ WPHCP (Physician) Name: ______

The PCP and WPHCP must have a referral arrangement.

If BlueCare Dental HMO: Office ID#: ______

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ **No** ☐ **Yes If Yes, the section below <u>must</u> be completed:**

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) (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.

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**

Reason: ☐ **Covered under spouse's employer-based health insurance plan (complete "Other Insurance Information" in ⑧)** ☐ **Covered under a Medicare supplement plan**

☐ **Other (please explain)** ______

Date Signed: ___/___/___ **Signature of Applicant:** ______