FORT DEARBORN LIFE INSURANCE COMPANY
CHICAGO, ILLINOIS
®Registered Marks of Fort Dearborn Life Insurance Company

BlueCross BlueShield of Illinois
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK BALL POINT PEN ONLY — PRESS HARD.

(1) ENROLLEE: ☐ Timely Enrollment ☐ Special Enrollment ☐ Late Enrollment ☐ COBRA ☐ Retiree ☐ Membership Change ☐ Open Enrollment

(2) EFFECTIVE DATE:	GROUP NUMBER:	SECTION NUMBER:	IDENTIFICATION NUMBER:	(3) COBRA: START DATE: __/__/__ END DATE: __/__/__	FOR USE BY BCBSI ONLY REASON CODE: ____ ____

(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.

- ☐ Traditional
- ☐ BlueAdvantage PPO
- ☐ Community Blue PPO
- ☐ BlueAdvantage HMO
- ☐ Predent: ☐ Single Dental ☐ Family Dental
  Group #: _____
- ☐ DentaCap
- ☐ Vision
- ☐ PPO/PPO Plus
- ☐ CPO (Community Participating Option)
- ☐ HMO Illinois
- ☐ Prescription Drugs
- ☐ Hearing

☐ Fort Dearborn Life: Group #: _____

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____

Identification #: _____

CHANGES

Date: __/__/__

- ☐ HMO Medical Group/IPA
- ☐ PCP and/or OB/GYN*
- ☐ Name
- ☐ Address
- ☐ Telephone
- ☐ Reinstate
- ☐ From PPO to HMO
- ☐ From HMO to PPO
- ☐ Medicare Coverage
- ☐ FDL Beneficiary

ADD DEPENDENTS

Date: __/__/__

- ☐ Marriage
- ☐ Newborn
- ☐ Adoption/Placement
- ☐ Legal Guardianship
- ☐ Other: _____

CANCEL DEPENDENTS

Date: __/__/__

- ☐ Marriage
- ☐ Divorce
- ☐ Age Limit
- ☐ Other: _____

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

CANCEL
(Check all that apply)

Date: __/__/__

- ☐ Terminate Coverage
- ☐ Voluntary Withdrawal**
- ☐ Leave/Layoff
- ☐ Out of Service Area Move
- ☐ Other: _____

***After checking the appropriate physician change, circle reason:**

- ☐ PCP
- ☐ OB/GYN

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 and sign Section (12).**

(6) EMPLOYEE INFORMATION: Company Name:

Last Name:	First Name:	Mid. Initial

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

Date of Birth: __/__/__ Are You Eligible for Family Coverage: ☐ No ☐ Yes Health Coverage Elected: ☐ Individual ☐ Family Sex: ☐ Male ☐ Female

Employee Social Security Number: _____ – _____ – _____

Telephone No.: Bus.: ( ) _____ Home: ( ) _____ Date of Hire: __/__/__

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

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____

Primary Care Physician Name: _____ WPHCP Medical Group/IPA #: _____

WPHCP Medical Group Name: _____ WPHCP (Physician) Name: _____

Employment Status: ☐ **Actively at Work** ☐ **Retired** ☐ **COBRA**

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

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: __/__/__	Start Date: __/__/__	Start Date: __/__/__
Start Date: __/__/__	End Date: __/__/__	End Date: __/__/__	End Date: __/__/__

(7) FAMILY COVERAGE INFORMATION: **List All Eligible Dependents.**

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

First Name: _____ Social Security Number: _____ – _____ – _____

If HMO: Medical Group/IPA #: _____ Medical Group/IPA Name: _____

Primary Care Physician Name: _____ WPHCP Medical Group/IPA #: _____

WPHCP Medical Group Name: _____ WPHCP (Physician) Name: _____

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

HIC #: _____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: __/__/__	Start Date: __/__/__	Start Date: __/__/__
Start Date: __/__/__	End Date: __/__/__	End Date: __/__/__	End Date: __/__/__

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(8) EMPLOYEE INFORMATION (continued): Company Name: Group #:

Last Name: | First Name: | Mid. Initial

(7) (B) ☐ SON ☐ DAUGHTER: Date of Birth: ___/___/___ Last Name (Only If Different): ______
First Name: ______ Social Security Number: ______ – ______ – ______
If HMO: Medical Group/IPA #: ______ Medical Group/IPA Name: ______
Primary Care Physician Name: ______ WPHCP Medical Group/IPA #: ______
WPHCP Medical Group Name: ______ WPHCP (Physician) Name: ______
Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**
HIC #: ______ MEDICARE B: ESRD DIALYSIS: DISABILITY:
MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___
Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

☐ SON ☐ DAUGHTER: Date of Birth: ___/___/___ Last Name (Only If Different): ______
First Name: ______ Social Security Number: ______ – ______ – ______
If HMO: Medical Group/IPA #: ______ Medical Group/IPA Name: ______
Primary Care Physician Name: ______ WPHCP Medical Group/IPA #: ______
WPHCP Medical Group Name: ______ WPHCP (Physician) Name: ______
Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**
HIC #: ______ MEDICARE B: ESRD DIALYSIS: DISABILITY:
MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___
Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

☐ SON ☐ DAUGHTER: Date of Birth: ___/___/___ Last Name (Only If Different): ______
First Name: ______ Social Security Number: ______ – ______ – ______
If HMO: Medical Group/IPA #: ______ Medical Group/IPA Name: ______
Primary Care Physician Name: ______ WPHCP Medical Group/IPA #: ______
WPHCP Medical Group Name: ______ WPHCP (Physician) Name: ______
Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**
HIC #: ______ MEDICARE B: ESRD DIALYSIS: DISABILITY:
MEDICARE A: Start Date: ___/___/___ Start Date: ___/___/___ Start Date: ___/___/___
Start Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___ End Date: ___/___/___

(9) 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 Card: 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: ______

(10) 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: ______

(11) **I APPLY FOR COVERAGE AS INDICATED ABOVE**, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Fort Dearborn Life Insurance Company (providing the life and disability insurance) which are herein called the Company. I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage. Upon presentation of the original or a photo-copy of this signed authorization, I authorize any medical professional, hospital, clinic, other medical or medically related facility, government agency, or other person or firm to provide information including copies of records concerning advice, care or treatment provided to me and/or my dependents including, without limitation, information relating to mental illness, use of drugs or alcohol, to the Company representatives involved in evaluating, determining or administering claims for insurance benefits for me and my dependents. I understand that I or any authorized representative will receive a copy of this authorization upon request.

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

(12) If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ Myself ☐ My spouse ☐ My spouse and dependents ☐ My dependents ☐ Myself, my spouse and my dependents

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