BlueCross BlueShield of Illinois

Dearborn National**
Underwritten by Fort Dearborn Life Insurance Company®

APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

① ENROLLEE: **New Enrollment:** ☐ Timely ☐ Special ☐ Late | **Open Enrollment:** ☐ New Member ☐ Plan Change ☐ Add Dependents

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.) ☐ 3. Dependent (reach age limit, other.)

☐ 2. Spouse (divorce from employee, death of employee, other.) ☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

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

Medical

☐ Traditional
☐ HMO Illinois
☐ w/HCA (BlueEdge HMO)
☐ BlueAdvantage HMO
☐ w/HCA (BlueEdge HMO)
☐ BlueEdge HSA
☐ PPO
☐ BlueEdge HCA
☐ Blue*Choice* Select
☐ BlueEdge Select HSA
☐ BlueEdge Select HCA
☐ BlueEdge Direct HCA
☐ BlueEdge Select Direct HCA
☐ BlueDecision PPO
☐ PPO Value Choice
☐ CPO
☐ CPO Value Choice
☐ Vision
☐ Hearing
☐ Medicare Supplement

Dental

☐ 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)

Dearborn National Group #: _____

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____

Identification #: _____

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.

CHANGES

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

ADD DEPENDENTS

Date: ___/___/___

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

CANCEL DEPENDENTS

Date: ___/___/___

☐ Divorce
☐ Age Limit
☐ Other: _____

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

CANCEL
(Check all that apply)

Date: ___/___/___

☐ Terminate Coverage
☐ Waive Coverage**
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other: _____

*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: City of Bernyn

Last Name:	First Name:	Mid. Initial	E-Mail Address:	Cell Phone Number

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: _____

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**

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

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

HIC #: _____
MEDICARE A:
Start Date: ___/___/___

MEDICARE B:
Start Date: ___/___/___
End Date: ___/___/___

ESRD DIALYSIS:
Start Date: ___/___/___
End Date: ___/___/___

DISABILITY:
Start Date: ___/___/___
End Date: ___/___/___

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ Ⓐ SPOUSE/DOMESTIC PARTNER:

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#:** _____

A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

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

HIC #: _____
MEDICARE A:
Start Date: ___/___/___

MEDICARE B:
Start Date: ___/___/___
End Date: ___/___/___

ESRD DIALYSIS:
Start Date: ___/___/___
End Date: ___/___/___

DISABILITY:
Start Date: ___/___/___
End Date: ___/___/___

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* Products and services marketed under the Dearborn National™ brand and the star logo are underwritten and/or provided by Fort Dearborn Life Insurance Company® (Downers Grove, IL) in all states (excluding New York), the District of Columbia, the United States Virgin Islands, the British Virgin Islands, Guam and Puerto Rico.

EMPLOYEE AND DEPENDENT INFORMATION: Company Name: City of BERWYN Group #: P51642

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: ________
Address (if different from Employee's address): 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*: ________
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 must 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: ________
Address (if different from Employee's address): 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*: ________
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 must 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: ________
Address (if different from Employee's address): 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*: ________
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 must 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 DEARBORN NATIONAL:

Employee Job Title: ________
Basic Salary: $ ________ **☐ Hourly ☐ Weekly ☐ Semi-Monthly ☐ Monthly ☐ Annually** **Class Type:** ________
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 Dearborn National (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:** ________

*A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.