Blue Cross Blue Shield of Illinois Enrollment application/change form Group #_____

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

Are you applying as a result of a Special Enrollment ?
__No __ Yes, Event Date:_____
Event: ___ New Hire ____ Marriage* _____Birth

___Adoption , Placement for Adoption or Suit for Adoption (provide legal Documents)
_____ Court order (provide court order or decree)
_____ Loss of Other Coverage

____Cancel Enrollee ____Cancel Dependent
Event _____
Indicate Event Date:_____

Effective Date of Benefits:_____

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

Last Name	First Name	Birth date(MM/DD/YYYY)	Social Security

Mailing Address - Street - Apt #	City	State	ZIP code

Email Address	___Male ___ Female	Home/Cell Phone #

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

Eligibility Status: ____ Retired Employee -_____ Date of Retirement: _____COBRA Coverage Start Date Projected End Date

SECTION 3 — SELECT YOUR COVERAGE

Danville CC School District 118

_____DEA and Admin (teacher, TA, Secretary, Admin)	_____ Food Service and Custodial

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Last Name: Social Security #:

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.)

Employee/Enrollee's Name	PCP Name PCP #	IPA Name IPA #
WPHCP Name WPHCP # / New Patient? ☐Y ☐N	HMO OB/GYN Name (optional)	HMO OB/GYN #

Dependent's Name ☐Husband ☐Wife ☐Domestic Partner ☐Party to a Civil Union	Dependent's PCP Name	PCP #	New Patient? ☐Y ☐N
IPA Name IPA #	WPHCP Name WPHCP #	HMO OB/GYN Name (optional) HMO OB/GYN #	
Dependent's Social Security # – – / Birth Date (MM/DD/YYYY)	Home Address (if different) Street/City/State/ZIP code		

Dependent's Name ☐Son ☐Daughter ☐Other Eligible Dependent	Dependent's PCP Name	PCP #	New Patient? ☐Y ☐N
Birth Date (MM/DD/YYYY) / Home Address (if different) Street/City/State/ZIP code	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	
Dependent's Social Security # – –	IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐Son ☐Daughter ☐Other Eligible Dependent	Dependent's PCP Name	PCP #	New Patient? ☐Y ☐N
Birth Date (MM/DD/YYYY) / Home Address (if different) Street/City/State/ZIP code	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	
Dependent's Social Security # – –	IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

Dependent's Name ☐Son ☐Daughter ☐Other Eligible Dependent	Dependent's PCP Name	PCP #	New Patient? ☐Y ☐N
Birth Date (MM/DD/YYYY) / Home Address (if different) Street/City/State/ZIP code	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	
Dependent's Social Security # – –	IPA Name IPA #	HMO OB/GYN Name (optional) HMO OB/GYN #	

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

Name of Disabled Dependent	Nature of Disability
Name of Disabled Dependent	Nature of Disability

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:**

Group Coverage ☐Yes ☐No	Individual Coverage ☐Yes ☐No	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		Birth Date (MM/DD/YYYY)	☐Male ☐Female	Relationship to Applicant ☐Self ☐Spouse ☐Dependent

Employer's Name	Employment Date (MM/DD/YYYY)	Health Group #	Health ID #	Dental Group #	Dental ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

Name of person covered:	Medicare A (Hospital) Effective Date: ____________ Medicare B (Medical) Effective Date: ____________ Medicare D (Drug) Effective Date: ____________ Medicare D (Drug) Carrier: ____________	End Date: ____________ End Date: ____________ End Date: ____________	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility:	☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease		
Name of person covered:	Medicare A (Hospital) Effective Date: ____________ Medicare B (Medical) Effective Date: ____________ Medicare D (Drug) Effective Date: ____________ Medicare D (Drug) Carrier: ____________	End Date: ____________ End Date: ____________ End Date: ____________	Medicare HIC # (From Medicare Card)
Please indicate reason for Medicare Eligibility:	☐ Entitled Age ☐ Entitled Disability ☐ End-Stage Renal Disease ☐ Disability and Current Renal Disease		

PCP #   New Patient?

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BlueCross BlueShield of Illinois

Section 8 — DECLINATION OF COVERAGE PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

This is to certify the available coverage has been explain€d to me. f have been given the opportunity to apply for the coverage offered to me and my eligible dependents and have voluntarily elected to degline the coverage as indicated below. ff I desire to apply for coverage at a later dater E understand there may be a delay in the effective date of the coverage.

Name Employee	Reason for declining Health: Other Group Health Coverage – Carrier _____ ___Medicare ____Medicaid Other Individual Health Coverage — Carrier:_____ ____Other (explain) ___ ___ I am not enrolled in any health insurance plan, but do not want this coverage
Name Employee	Reason for declining Dental: __ Other Group Dental Coverage ___Medicaid Other (explain)
Name Spouse	Reason for declining: ____Other Group Health Coverage ____Medicare _____Medicaid ___ Other Individual Health Coverage ___Other (explain) ___I am not enrolled in any health insurance plan, but do not want this coverage
Name Dependent	Reason for declining: ____Other Group Health Coverage ___ Medicare ___Medicaid ____ Other Individual Health Coverage ___Other (explain) __I am not enrolled in any health insurance plan, but do not want this coverage
Name Dependent	Reason for declining:___Other Group Health Coverage ____ Medicare ____ Medicaid ____ Other Individual Health Coverage ___ Other (explain) ___I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Ilfinojs or Dearborn NationaP Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me Will invalidate my coverage(s).
- Only Contract(s)/Plarthose coverage(s) and amounts for which I am eligible witl be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my empbyer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicabla to me.

ANY PERSON KNOWINGLY PRESENTS A FALSE OR FRAUDULENTCI.AIM FOR PAYMEIWOF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CML FINES AND CRIMINAL PENALTIES.

Applicant's Signature :_____ Date:_____

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
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
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
200 Independence Avenue SW
Room 509F, HI-IH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html