BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

300 E. Randolph St.
Chicago, IL 60601

Or call us at the phone number on the back of your identification card

Group Enrollment Application/Change Form

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

232320.0425

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM. **USE A BLACK OR BLUE BALLPOINT PEN ONLY. PRINT NEATLY. DO NOT ABBREVIATE.**

SECTION 1 ENROLLMENT EVENTS	Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection. **New Enrollee:** Complete all sections where applicable. **Add Dependent:** Complete all sections where applicable. • If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section. • If your employer offers coverage for children and your children are eligible, your children are eligible for health and/or dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26 (check with your employer for additional details regarding eligibility requirements). In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law. If you are adding an eligible military personnel dependent who is over the age limit of the employer's plan, completion of a Defense Department Form (DD 214) is required in addition to this application. **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership. **Special Enrollment Event:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption or placement for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment. **Effective Date of Benefits:** Field is mandatory and should reflect your requested date. **Completion of Other Eligibility Requirements:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period. **Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.
SECTION 2 YOUR INFORMATION	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 YOUR COVERAGE	Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example: S533PPO) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer. If you are enrolling for life or disability insurance enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.
SECTION 4 COVERAGE OPTIONS	Complete all areas that apply to you and each dependent. For HMO Plans Only: • Those applying for HMO coverage are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at bcbsil.com. Be sure to check the appropriate box for a new patient. • If you selected HMO coverage, you must select a medical group/individual practice associations (IPAs) and a primary care physician (PCP) for each person to be covered. You must also select a PCP within the selected medical group/IPA for each person to be covered. You may choose a different medical group/IPA for each person. Care received from a woman's principal health care provider (WPHCP) may be eligible for coverage without referrals from your PCP. However, your PCP and your WPHCP must be affiliated with or employed by your medical group/IPA in order for each person to be eligible for coverage. Until we receive your selected medical group/IPA, you may not be eligible and your claims may be denied. Be sure to enter the medical group/IPA number, name, PCP number and name. • 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. Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, name and number of the new PCP and the name and number of the new IPA. Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.
SECTION 5 DISABLED DEPENDENT	A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if dependent coverage is part of your employer's plan. The disabled dependent is required to be covered prior to age 26 to be eligible for coverage over the dependent child age limit of your employer's plan. A Disabled Dependent Authorization and Disabled Dependent Physician Certification document must be completed and submitted with this enrollment application, if applicable.
SECTION 6 OTHER COVERAGE	Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.
SECTION 7 MEDICARE COVERAGE	Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.
SECTION 8 DECLINATION OF COVERAGE	Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 8, not just those declining because of other coverage. **IMPORTANT NOTICE:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, party to a civil union, birth, adoption, becoming a party in a suit for adoption, or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement for adoption, or placement of an eligible foster child in your home.
SECTION 9 COVERAGE CONDITIONS	SIGN YOUR NAME AND DATE THE ENROLLMENT APPLICATION IF YOU AGREE TO THE CONDITIONS SET FORTH IN THIS SECTION. YOUR ENROLLMENT APPLICATION SHOULD BE SUBMITTED TO YOUR EMPLOYER'S ENROLLMENT DEPARTMENT, WHICH WILL THEN SUBMIT YOUR FORM TO BCBSIL.

AS USED ON THE APPLICATION (UNLESS INDICATED OTHERWISE): THESE TERMS MAY BE USED IN A DIFFERENT WAY IN OTHER DOCUMENTS.

* THE TERM "MARRIAGE" INCLUDES LEGAL MARRIAGE AND THE ESTABLISHMENT OF A CIVIL UNION OR DOMESTIC PARTNERSHIP (COVERAGE SUBJECT TO YOUR EMPLOYER'S PLAN).

** THE TERM "DIVORCE" INCLUDES LEGAL DIVORCE AND THE COMPARABLE TERMINATION OF A CIVIL UNION OR DOMESTIC PARTNERSHIP (COVERAGE SUBJECT TO YOUR EMPLOYER'S PLAN).

*** THE TERM "SPOUSE" INCLUDES A LEGAL SPOUSE AND A PARTY TO A CIVIL UNION OR DOMESTIC PARTNERSHIP (COVERAGE SUBJECT TO YOUR EMPLOYER'S PLAN).

CHANGES IN STATE OR FEDERAL LAW OR REGULATIONS, OR INTERPRETATIONS THEREOF, MAY CHANGE THE TERMS AND CONDITIONS OF COVERAGE.

IF YOU ARE A CURRENT MEMBER AND HAVE QUESTIONS, YOU MAY CALL THE CUSTOMER SERVICE NUMBER ON THE BACK OF YOUR MEMBER ID CARD.

GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY

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** ☐ **OTHER CHANGES**

ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT? ☐ 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

☐ OTHER (EXPLAIN):

EFFECTIVE DATE OF BENEFITS:

☐ **COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS**

☐ **CANCEL ENROLLEE** ☐ **CANCEL DEPENDENT**

CANCEL COVERAGE: ☐ HEALTH ☐ DENTAL ☐ TERM LIFE

☐ DEPENDENT LIFE ☐ SUPPLEMENTAL LIFE ☐ STANDALONE VISION

☐ SHORT-TERM DISABILITY ☐ LONG-TERM DISABILITY ☐ CRITICAL ILLNESS

☐ ACCIDENT INSURANCE ☐ HOSPITAL INDEMNITY

LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW

EVENT: ☐ DIVORCE** ☐ DEATH ☐ TERMINATED EMPLOYMENT ☐ OTHER

INDICATE EVENT DATE:

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

LAST NAME	FIRST NAME	MI (OPT)	SUFFIX	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #

MAILING ADDRESS - STREET - APT #	CITY	STATE	ZIP CODE

EMAIL ADDRESS	☐ MALE ☐ FEMALE	HOME/CELL PHONE #	PRIMARY LANGUAGE

NAME OF EMPLOYER	JOB TITLE	BUSINESS PHONE #	EMPLOYMENT DATE (MM/DD/YYYY)	ON AVERAGE, HOW MANY HOURS A WEEK DO YOU WORK? (REQUIRED)

ELIGIBILITY STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED EMPLOYEE - DATE OF RETIREMENT:

☐ COBRA COVERAGE START DATE PROJECTED END DATE

☐ ILLINOIS CONTINUATION (INSURED PLANS ONLY) START DATE PROJECTED END DATE

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

SMALL GROUP PLANS (1-50 EMPLOYEES)

AFFORDABLE CARE ACT PLANS

☐ PPO ☐ OTHER

☐ BLUE CHOICE PREFERRED PPO℠

☐ BLUE OPTIONS℠

☐ BLUE PRECISION HMO℠

☐ BLUECARE DIRECT℠ PLAN # (REQUIRED)

GRANDFATHERED AND GRANDMOTHERED/TRANSITIONAL PLANS

☐ BLUE ADVANTAGE ENTREPRENEUR PPO℠

☐ BLUE CHOICE SELECT PPO℠

☐ BLUE EDGE SELECT HSA℠

☐ BLUE EDGE HSA℠

☐ BLUE EDGE HCA DIRECT℠

☐ PPO VALUE CHOICE

☐ BLUE ADVANTAGE HMO℠

☐ BLUE ADVANTAGE HMO VALUE CHOICE℠

☐ COMMUNITY PARTICIPATION ORGANIZATION (CPO)

☐ CPO VALUE CHOICE

☐ OTHER

PLAN # (REQUIRED)

MID-MARKET AND LARGE GROUP STANDARD PLANS (51+ EMPLOYEES)

☐ PPO

☐ BLUE CHOICE OPTIONS℠

☐ BLUE EDGE SELECT HSA℠

☐ BLUE ADVANTAGE HMO℠

☐ BLUE CHOICE SELECT PPO℠

☐ PLAN # (REQUIRED)

☐ BLUE ADVANTAGE HMO VALUE CHOICE℠

☐ BLUE EDGE HSA℠

☐ OTHER

PREVIOUS BCBSIL OR HMO MEMBERSHIP

GROUP #:

SECTION #:

IDENTIFICATION #:

LARGE GROUP CUSTOM PLANS (151+ EMPLOYEES)

☐ TRADITIONAL

☐ PPO

☐ CPO

☐ CPO VALUE CHOICE

☐ HMO ILLINOIS®

☐ HMO ILLINOIS® W/HCA

☐ BLUE ADVANTAGE HMO℠

☐ BLUE ADVANTAGE HMO℠ W/HCA

☐ BLUE CHOICE OPTIONS℠

☐ BLUE CHOICE SELECT PPO℠

☐ BLUE EDGE HCA℠

☐ BLUE EDGE HSA℠

☐ BLUE EDGE HCA DIRECT℠

☐ BLUE EDGE SELECT HCA℠

☐ MEDICARE SUPPLEMENT

☐ OTHER

☐ BLUE EDGE SELECT HSA℠

☐ BLUE EDGE SELECT HCA DIRECT℠

☐ VISION

☐ HEARING

DENTAL

☐ BLUECARE DENTAL PPO℠ ☐ BLUECARE DENTAL HMO℠

☐ DENTAL GROUP #
(IF DIFFERENT THAN MEDICAL GROUP POLICY #)

☐ EMPLOYEE AND PARTY TO A CIVIL UNION OR DOMESTIC PARTNER ☐ MALE ☐ FEMALE

☐ INDIVIDUAL/EMPLOYEE ☐ EMPLOYEE/SPOUSE

☐ EMPLOYEE/CHILDREN ☐ FAMILY

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D), DISABILITY, ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY AND STANDALONE VISION INSURANCE

☐ I AM NOT APPLYING FOR GROUP TERM LIFE, AD&D, DISABILITY, ACCIDENT, CRITICAL ILLNESS, HOSPITAL INDEMNITY OR STANDALONE VISION INSURANCE COVERAGE

EMPLOYEE OCCUPATION/JOB TITLE: WAGE RATE $ PER ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

GROUP BASIC TERM LIFE AND AD&D	☐ I DO NOT APPLY	☐ I DO APPLY	AMOUNT $			
GROUP DEPENDENTS' LIFE	☐ I DO NOT APPLY	☐ I DO APPLY				
GROUP SUPPLEMENTAL LIFE	☐ I DO NOT APPLY	☐ I DO APPLY	EMPLOYEE ELECTION: $	SPOUSE ELECTION: $	CHILD ELECTION: $	
SHORT-TERM DISABILITY	☐ I DO NOT APPLY	☐ I DO APPLY	LONG-TERM DISABILITY	☐ I DO NOT APPLY	☐ I DO APPLY	
CRITICAL ILLNESS	☐ I DO NOT APPLY	☐ I DO APPLY	EMPLOYEE ELECTION: $	SPOUSE ELECTION: $	CHILD ELECTION: $	
ACCIDENT	☐ I DO NOT APPLY	☐ I DO APPLY	☐ INDIVIDUAL/EMPLOYEE	☐ EMPLOYEE/SPOUSE	☐ EMPLOYEE/CHILD	☐ FAMILY
HOSPITAL INDEMNITY	☐ I DO NOT APPLY	☐ I DO APPLY	☐ INDIVIDUAL/EMPLOYEE	☐ EMPLOYEE/SPOUSE	☐ EMPLOYEE/CHILD	☐ FAMILY
STANDALONE VISION	☐ I DO NOT APPLY	☐ I DO APPLY	☐ INDIVIDUAL/EMPLOYEE	☐ EMPLOYEE/SPOUSE	☐ EMPLOYEE/CHILD	☐ FAMILY

	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
PRIMARY BENEFICIARY						
CONTINGENT BENEFICIARY						

LAST NAME	SOC. SEC. #	GROUP #

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? ☐ YES ☐ NO	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? ☐ YES ☐ NO
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? ☐ YES ☐ NO
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? ☐ YES ☐ NO	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? ☐ YES ☐ NO
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? ☐ YES ☐ NO
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? ☐ YES ☐ NO	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? ☐ YES ☐ NO
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? ☐ YES ☐ NO
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? ☐ YES ☐ NO	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? ☐ YES ☐ NO
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 IF APPLICABLE

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		

Blue Cross and Blue Shield 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

LAST NAME	SOC. SEC. #	GROUP #

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

THIS IS TO CERTIFY THE AVAILABLE COVERAGE HAS BEEN EXPLAINED TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE COVERAGE OFFERED TO ME AND MY ELIGIBLE DEPENDENTS AND HAVE VOLUNTARILY ELECTED TO DECLINE THE COVERAGE AS INDICATED BELOW. IF I DESIRE TO APPLY FOR COVERAGE AT A LATER DATE, I 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 ☐ INDIVIDUAL DENTAL COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY DENTAL INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE	
NAME ☐ SPOUSE	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ 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 ☐ MEDICAID ☐ 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 ☐ MEDICAID ☐ 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 issued by Blue Cross and Blue Shield of Illinois or Dearborn 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 those coverage(s) and amounts for which I am eligible will 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 Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, 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 applicable to me.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

APPLICANT'S SIGNATURE DATE

Non-Discrimination Notice

Health care coverage is important for everyone.

We do not discriminate on the basis of race, color, national origin (including limited English knowledge and first language), age, disability, or sex (as understood in the applicable regulation). We provide people with disabilities with reasonable modifications and free communication aids to allow for effective communication with us. We also provide free language assistance services to people whose first language is not English.

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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	Email:	civilrightscoordinator@bcbsil.com

You can file a grievance in person or by mail, fax or email. If you need help filing a grievance, the Office of Civil Rights Coordinator is available to help you.

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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Complaint Portal:	ocrportal.hhs.gov/ocr/smartscreen/main.jsf
Washington, DC 20201	Complaint Forms:	hhs.gov/civil-rights/filing-a-complaint/index.html

This notice is available on our website at bcbsil.com/legal-and-privacy/non-discrimination-notice

BlueCross BlueShield
of Illinois

ATTENTION: If you speak another language, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 855-710-6984 (TTY: 711) or speak to your provider.

Español Spanish	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 855-710-6984 (TTY: 711) o hable con su proveedor.
العربية Arabic	تنبيه: إذا كنت تتحدث اللغة العربية، فستتوفر لك خدمات المساعدة اللغوية المجانية. كما تتوفر وسائل مساعدة وخدمات مناسبة لتوفير المعلومات بتنسيقات يمكن الوصول إليها مجانًا. اتصل على الرقم 855-710-6984 (TTY: 711) أو تحدث إلى مقدم الخدمة.
中文 Chinese	注意：如果您说中文，我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务，以无障碍格式提供信息。致电 855-710-6984（文本电话：711）或咨询您的服务提供商。
Français French	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 855-710-6984 (TTY : 711) ou parlez à votre fournisseur.
Deutsch German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 855-710-6984 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
ગુજરાતી Gujarati	ધ્યાન આપો: જો તમે ગુજરાતી બોલતા હો તો મફત ભાષાકીય સહાયતા સેવાઓ તમારા માટે ઉપલબ્ધ છે. યોગ્ય ઑક્ઝિલરી સહાય અને ઍક્સેસિબલ ફૉર્મેટમાં માહિતી પૂરી પાડવા માટેની સેવાઓ પણ વિના મૂલ્યે ઉપલબ્ધ છે. 855-710-6984 (TTY: 711) પર કૉલ કરો અથવા તમારા પ્રદાતા સાથે વાત કરો.
हिंदी Hindi	ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपके लिए निःशुल्क भाषा सहायता सेवाएं उपलब्ध होती हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक साधन और सेवाएँ भी निःशुल्क उपलब्ध हैं। 855-710-6984 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Italiano Italian	ATTENZIONE: se parli Italiano, sono disponibili servizi di assistenza linguistica gratuiti. Sono inoltre disponibili gratuitamente ausili e servizi ausiliari adeguati per fornire informazioni in formati accessibili. Chiama l'855-710-6984 (tty: 711) o parla con il tuo fornitore.
한국어 Korean	주의: 한국어 를 사용하시는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 이용 가능한 형식으로 정보를 제공하는 적절한 보조 기구 및 서비스도 무료로 제공됩니다. 855-710-6984(TTY: 711)번으로 전화하거나 서비스 제공업체에 문의하십시오.
Diné Navajo	SHOOH: Diné bee yáníłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 855-710-6984 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
فارسي Farsi	توجه: اگر فارسي صحبت می‌کنید، خدمات پشتیبانی زبانی رایگان در دسترس شما قرار دارد. همچنین کمک‌ها و خدمات پشتیبانی مناسب برای ارائه اطلاعات در قالب‌های قابل دسترس، به‌طور رایگان موجود می‌باشند. با شماره 855-710-6984 (تله‌تایپ: 711) تماس بگیرید یا با ارائه‌دهنده خود صحبت کنید.
Polski Polish	UWAGA: Osoby mówiące po polsku mogą skorzystać z bezpłatnej pomocy językowej. Dodatkowe pomoce i usługi zapewniające informacje w dostępnych formatach są również dostępne bezpłatnie. Zadzwoń pod numer 855-710-6984 (TTY: 711) lub porozmawiaj ze swoim dostawcą.
РУССКИЙ Russian	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 855-710-6984 (TTY: 711) или обратитесь к своему поставщику услуг.
Tagalog Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 855-710-6984 (TTY: 711) o makipag-usap sa iyong provider.
اردو Urdu	توجہ دیں: اگر آپ اردو بولتے ہیں، تو آپ کے لیے زبان کی مفت مدد کی خدمات دستیاب ہیں۔ قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے مناسب معاون امداد اور خدمات بھی مفت دستیاب ہیں۔855-710-6984 (711:TTY) پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Việt Vietnamese	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 855-710-6984 (Người khuyết tật: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.