BlueCross BlueShield of Illinois

Blue Cross and Blue Shield of Illinois Cover Page to the **Illinois Standard Health Employee Application for Small Employers**

(Groups sized 2 - 150)

The purpose of this document is to help you – an employee requesting coverage from Blue Cross and Blue Shield of Illinois (BCBSIL) – fill out the new standard enrollment application created by the State of Illinois Department of Insurance.

As a result of the Illinois Insurance Fairness Act (Public Act 96-0857), the Illinois Department of Insurance created standard enrollment applications that must be used by all insurance companies doing business in the small group and individual markets.

The attached standard application goes into effect January 1, 2011 and replaces the small group enrollment applications previously used by insurance companies.

Although all insurance companies must use this standard enrollment application, the business needs and practices of all insurance companies are not the same. Not all the information requested on the new standard enrollment application is required by BCBSIL. However, there is information BCBSIL needs for the enrollment process that is not on the standard enrollment application.

The information below will help you understand how to complete each section of the standard enrollment application for enrollment with BCBSIL.

1. Employer Information

Your employer can use the Illinois Standard Health Employee Application with one or more insurance companies to request quotes for employee health insurance. This standard enrollment application means you do not need to fill out different applications from each insurance company. For your benefit, space is provided on the standard enrollment application so your employer can list the different insurance companies that will receive your health information.

You will see references to "spouse/domestic partner" and "retiree" in the standard enrollment application. Domestic partners and retirees are eligible only if your employer chooses to cover them. Check with your employer if you are not sure.

2. Section B – Coverage Requested

Choose the type of health coverage/product you want based on the option(s) your employer has offered you.

- Some employers may offer only one type of coverage such as a PPO health benefit plan.
- Others may provide different options such as a PPO, an HMO, and/or a plan that includes a Health Savings Account (HSA) and/or a Health Care Account (HCA).
- You and your dependents (spouse/domestic partner and children) will all be enrolled in the same product. You cannot pick different products for each person.

BCBSIL offers the following products for small group business. If you are not sure which product(s) are available to you, please ask your employer.

PPO	HMO	HSA	HCA
• BlueAdvantage℠ Entrepreneur PPO • BluePrint PPO • Blue*Choice* Select® • PPO Value Choice • CPO • CPO Value Choice	• BlueAdvantage℠ HMO • HMO Value Choice	• BlueEdge℠ HSA • BlueEdge℠ Select HSA	• BlueEdge℠ Direct HCA • BlueEdge℠ Select Direct HCA

3. Section C – Waiver of Coverage

You may enroll yourself and your dependents (spouse/domestic partner and children) in any coverage that your employer makes available to you, and that BCBSIL offers. While the standard enrollment application may appear to suggest that you can waive enrolling yourself for coverage but still enroll your dependents, BCBSIL's policy requires that you (the employee) enroll in order to also enroll your dependents. If you choose to waive any coverage, your dependents cannot enroll in that coverage. However, you can enroll yourself in a coverage and choose to waive it for any of your dependents.

Please use this section to indicate if you do not wish to enroll yourself and/or any of your dependents in the following types of coverage:

- Medical
- Dental
- Basic Life
- Dependent Life
- Short-Term Disability (*BCBSIL offers only to employees*)
- Voluntary Life (*BCBSIL offers only to employees*)

While you may see these types of coverage on the standard application, they are not available from BCBSIL for small group business:

- Vision
- Long-Term Disability

For small group business, BCBSIL does not consider "*Individual Coverage*" (*the second option on the standard application*) as a valid reason to decline your employer-offered coverage.

4. Section D – Individuals Requesting Coverage

- **Weight and Height -** BCBSIL requires the weight and height for yourself and your spouse/domestic partner. BCBSIL also requests weight and height be provided for any dependent that is 18 or older.
- **Military Veteran Dependents -** If you have dependents that are military veterans, you must include their honorable discharge documentation (Form DD-214).
- **Disabled Dependents -** Medical certification must be provided for disabled dependents.
- **HMO Coverage -** If you have elected to enroll in HMO coverage, information about your Primary Care Physician (PCP) is needed. The standard enrollment application provides space for your PCP and his or her identification number. However, BCBSIL requires more information about your physician. To accommodate this, a separate *HMO / CPO Provider Selection Enrollment and Change Form* is also required for HMO enrollees. This form is used to collect the following information:
  - Independent Practice Association (IPA) / Medical Group Number – this is required for BCBSIL to correctly identify the location you have chosen to access care from your PCP.
  - PCP name and the identification number.
  - Female enrollees may also choose a Woman's Principal Health Care Provider (WPHCP), so there is space to list this provider's name and identification number as well.
- **CPO Coverage -** BCBSIL offers a Community Participating Option (CPO) health benefit plan. This is similar to a PPO health benefit plan, but the member can gain greater savings by using providers at specific hospitals in the CPO network. Therefore, if you have chosen the CPO product, please use the *HMO / CPO Provider Selection Enrollment and Change Form* to indicate the number of the CPO network you have selected.

5. Section E – Current / Prior Coverage Information: Medicare

For small group business, "Dual Enrollment" is not an applicable Medicare entitlement reason for BCBSIL.

6. Sections F & G – Health Statement / Additional Information

This section should be completed by employees of groups that have 2-50 enrolling employees. If you are not sure about completing this section, check with your employer.

- For health coverage, BCBSIL does not require the health statement questions to be completed by employees of groups that have more than 50 employees enrolling.
- For basic life coverage, the health statement questions must be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment.
- Two pages are left blank so that information in these sections can be pulled out for underwriting (if applicable).

7. Section H – Additional Coverage Options

As stated in item #3, the following types of coverage are not available from BCBSIL for small group business:

- Vision
- Long-Term Disability

Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY
Policy/Group No.
Section No.
Effective Date
New Hire Waiting Period

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:
(To be completed by employer)
Insurer: _____ Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____ Insurer: _____

TO BE COMPLETED BY EMPLOYER

Employer Name: | Phone #:

Address:

Reason for Enrollment (Mark all that apply)

New Enrollment: ☐ New Group ☐ Open Enrollment ☐ New Hire (Date: _____) ☐ Late Enrollee

Special Enrollment: ☐ Adoption ☐ Court Order ☐ Dependent Addition ☐ Divorce ☐ Domestic Partner ☐ Loss of Coverage ☐ Marriage ☐ Newborn ☐ Other Date of Event: _____/_____/_____

Employment Status: ☐ Active ☐ Retiree (Retirement Date: _____/_____/_____) ☐ Illinois Continuation ☐ COBRA ☐ Employee ☐ Dependent
Qualifying Event: _____
Start Date _____/_____/_____ Projected End Date _____/_____/_____

A Employee Information

Name (Last) | (First) | (MI)

Job Title: | Hire Date: | Hrs/Week:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home Address: | Apt #:

City: | State: | Zip:

Home (or Cell) Phone: ( ) | Business Phone: ( )

Email Address (optional):

B Coverage Requested

Medical

Employee: ☐ Yes ☐ No	Spouse/Domestic Partner: ☐ Yes ☐ No	Child(ren): ☐ Yes ☐ No
Plan Choice:	Plan Choice:	Plan Choice:

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.

Employer Name _____ Employee Name _____

C Waiver of Coverage

Please complete this section only if **you are waiving (declining) coverage** for yourself or one or more of your family members.

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child, I may be considered a late enrollee, if applicable, or I may have to wait until the plan's next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I DO NOT want, and hereby waive, coverage for (initial next to all that apply):

Medical for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Dental* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Vision* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Basic Life* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Dependent Life* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Voluntary Life* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Short-Term Disability* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)
Long-Term Disability* for	[ ] Myself	[ ] My Spouse/Domestic Partner	[ ] My Dependent Child(ren)

✶ If offered.

I am **declining** group coverage for the following reason(s): (check all that apply)

☐ Spouse/Domestic Partner's Employer Plan ☐ Individual Coverage (Non-Group Plan)
☐ COBRA/State Continuation ☐ Medicare or other Government Program
☐ Other (please explain): _____

✪ If you are declining ALL coverage for ALL persons, please skip to the Acknowledgement & Signature section on page 10 of this application.

Employer Name ______________________________ Employee Name ____

D Individuals Requesting Coverage

List yourself and all eligible family members to be included under coverage.

- Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy.
- Illinois' Young Adult Dependent Coverage law allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, regardless of whether the child may be considered a dependent for tax or other purposes. For more information, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Spouse/Domestic Partner Name (Last) _________________________ (First) _________________________ (MI) ______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: Physician ID:

Employer Name _____ Employee Name _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: | Date of Birth: / /

Weight: lbs. | Height: ft. in. | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

HMO only (if/when applicable): Primary Care Physician: | Physician ID:

E Current/Prior Coverage Information

Please indicate for EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within **24 months** prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the **past 24 months**, please indicate **NONE.** If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. You will be subject to an automatic PEC Waiting Period of up to 12 months until the insurer receives evidence of prior coverage.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____
▶ Will the individual continue this coverage? ☐ Yes ☐ No

▶ **Prior Coverage (if any):** ☐ Group Medical ☐ Dental ☐ Individual Medical ☐ None
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
Policyholder Name: _____ Insurer Name: _____

Employer Name ______________________________ Employee Name ____

Dependent Name (Last) ______________________________ (First) ______________________________ (MI) ______

▶ **Current/Most Recent Coverage:** ☐Group Medical ☐Dental ☐Individual Medical ☐None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________
▶ Will the individual continue this coverage? ☐Yes ☐No

▶ **Prior Coverage (if any):** ☐Group Medical ☐Dental ☐Individual Medical ☐None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________

Dependent Name (Last) ______________________________ (First) ______________________________ (MI) ______

▶ **Current/Most Recent Coverage:** ☐Group Medical ☐Dental ☐Individual Medical ☐None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________
▶ Will the individual continue this coverage? ☐Yes ☐No

▶ **Prior Coverage (if any):** ☐Group Medical ☐Dental ☐Individual Medical ☐None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________

Dependent Name (Last) ______________________________ (First) ______________________________ (MI) ______

▶ **Current/Most Recent Coverage:** ☐Group Medical ☐Dental ☐Individual Medical ☐None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________
▶ Will the individual continue this coverage? ☐Yes ☐No

▶ **Prior Coverage (if any):** ☐Group Medical ☐Dental ☐Individual Medical ☐None
Dates of Coverage: From: ________/________/________ To: ________/________/________
Policyholder Name: ________________________________ Insurer Name: ________________________________

Medicare: If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name (Last) __________________________ (First) __________________________ (MI) ______

Medicare ☐Part A ☐Part B ☐Part D
Effective Date: ________/________/________
Reason for Medicare Entitlement: ☐Age ☐Disability ☐ERSD ☐Dual Enrollment

Medicare Number (please include alpha prefix):

Enrolling Individual Name (Last) __________________________ (First) __________________________ (MI) ______

Medicare ☐Part A ☐Part B ☐Part D
Effective Date: ________/________/________
Reason for Medicare Entitlement: ☐Age ☐Disability ☐ERSD ☐Dual Enrollment

Medicare Number (please include alpha prefix):

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Employer Name _____ Employee Name _____

F Health Statement

Instructions:

1. The information you provide in this application is confidential. You should discuss with your employer if you prefer to submit the completed health statement directly to the insurance company or insurance broker.
2. The health information you provide below will be used by the insurance company to determine the price to charge your group for the coverage applied for and whether a Pre-Existing Condition Waiting Period(s) will apply to your coverage. Coverage for pre-existing conditions cannot be limited or excluded for dependents under the age of 19.
3. Each medical question below applies to all persons requesting coverage.
4. Answer the questions below with either Yes or No. If you answer Yes to any question, you must provide additional information in Section G below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or may authorize you to provide anything less than a complete and accurate response to each of the questions.
7. After you submit this application, the insurance company may call you to obtain additional confidential information needed to evaluate and aid the processing of your application.

1 For the following conditions, **within the past 5 years**, have you or any dependents for whom you are requesting coverage:

- Been tested for or diagnosed with;
- Had medical treatment recommended;
- Received medical treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition related to any of the categories listed below?

A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels?	☐ Yes	☐ No
B. Cancer or cancerous tumor?	☐ Yes	☐ No
C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system?	☐ Yes	☐ No
D. Diabetes? If yes, check all that apply: ☐ Non-Insulin Dependent ☐ Insulin Dependent ☐ Insulin Pump	☐ Yes	☐ No
E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines?	☐ Yes	☐ No
F. Growth disorder or a disorder of the pancreas?	☐ Yes	☐ No
G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder?	☐ Yes	☐ No
H. Reproductive organ disorders or infertility?	☐ Yes	☐ No
I. Arthritis, or any other disorder of the joints, muscles, back, or bones?	☐ Yes	☐ No
J. Mental or emotional disorder?	☐ Yes	☐ No
K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system?	☐ Yes	☐ No

Employer Name _____ Employee Name _____

L. HIV positive, AIDS, diseases associated with AIDS, lupus, or other disorder of the immune system?	☐ Yes	☐ No
M. Alcohol, drug, or substance use or dependency?	☐ Yes	☐ No
N. Organ or bone marrow transplant?	☐ Yes	☐ No
2 Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant?	☐ Yes	☐ No
Due Date: _____/_____/_____ (MM/DD/YYYY)		
If yes, are multiples (twins, triplets, *etc.*) expected?	☐ Yes	☐ No
Are there any known complications, or is a cesarean section planned?	☐ Yes	☐ No
3 **Within the past 12 months,** have you or your spouse/domestic partner used any tobacco products? Employee:	☐ Yes	☐ No
Spouse/Domestic Partner:	☐ Yes	☐ No
4 **Within the past 12 months**, has any applicant been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application?**	☐ Yes	☐ No
5 **Within the past 5 years**, has any person applying for coverage been tested for or diagnosed with, had medical treatment recommended, received medical treatment, including prescription medications, or been hospitalized for **any illness, injury or health condition not indicated above?**	☐ Yes	☐ No

G Additional Information

If you answered "Yes" to <u>any</u> of the questions above, you must complete this section.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Question Number: _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Question Number: _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Employer Name ______________________________ Employee Name ____

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

Question Number: _________ Name of Individual: ____

Condition/Diagnosis: ________________________________ Date Diagnosed (MM/YYYY): ______________

Treatment Received: ____

____

Treatment ongoing? ☐ Yes ☐ No Last Treatment Date: ______________________________

Surgery, additional tests or treatment recommended? ______________________________

Medication Prescribed (if any): ____

____ Currently taking medication? ☐ Yes ☐ No

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Employer Name _____ Employee Name _____

H Additional Coverage Options

You should complete this section only if your employer offers any of the additional coverage options below.

Employee

▶ ☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): _____

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $_____

☐ Short-Term Disability ☐ Long-Term Disability

▶ Employee Class (employer will provide you with this information if needed): _____

▶ Salary (if requesting life or disability coverage): $_____

☐ Hourly ☐ Weekly ☐ Monthly ☐ Semi-monthly ☐ Annually

Spouse/Domestic Partner

▶ ☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): _____

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $_____

☐ Short-Term Disability ☐ Long-Term Disability

Child(ren)

▶ ☐ Dental: ☐ PPO ☐ HMO

Dental HMO Office ID # (if applicable): _____

☐ Vision ☐ Basic Life ☐ Dependent Life ☐ Voluntary Life: Amount (if applicable): $_____

☐ Short-Term Disability ☐ Long-Term Disability

Beneficiary Information (if requesting life insurance)

Primary Beneficiary Name (Last, First, MI) _____

Relationship _____ Benefit % _____

Secondary Beneficiary Name (Last, First, MI) _____

Relationship _____ Benefit % _____

Employer Name _____ Employee Name _____

I Acknowledgement & Signature

I understand, agree, and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature _____Date _____

✪ For assistance in completing this application, please contact your employer or insurance agent.
For information about your health care rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

BlueCross BlueShield of Illinois

HMO/CPO Provider Selection

Enrollment and Change Form

Please print clearly in ink. This form should be used to complete your Blue Cross and Blue Shield of Illinois (BCBSIL) HMO or CPO coverage enrollment and is required in addition to the Illinois Standard Health Employee Application. This form can also be used to change your HMO providers or CPO network selections. Please complete all sections for yourself, your spouse/domestic partner and your dependents. If more space is required, a copy of this form or a separate piece of paper may be attached.

If Your Are Enrolling/Changing HMO Coverage

- You must select a Medical Group or IPA (Independent Practice Association) and a Primary Care Physician (PCP) for each person to be covered.
- Please enter the name and numbers for both the Medical Group/IPA selection and the PCP selection for each person. If available, also enter the National Provider Identification (NPI) number.
- The Medical Group/IPA number is 3 digits. The PCP number is 9 digits. The NPI number is 10 digits.
- The PCP selected must be from within your Medical Group/IPA.
- You may choose a different Medical Group/IPA for each person.
- Female members may also choose a Woman's Principal Health Care Provider (WPHCP) from within your Medical Group/IPA. A WPHCP may be seen for care without referrals from your PCP, however, the WPHCP must be affiliated with or employed by your Medical Group/IPA.
- Medical Group/IPA, PCP, WPHCP and NPI provider information can be found using the Provider Finder® tool on *bcbsil.com*.
- Until we receive this information, you are not eligible to receive medical services and your claims could be denied.

If You Are Enrolling/Changing CPO Coverage

- You must select a CPO Network that will apply to all persons being covered.
- Please enter the name and number of the CPO Network
- The CPO Network number is 3 or 4 characters: the letters "CO" followed by 1 or 2 digits.
- CPO Network information can be found using the Provider Finder tool on *bcbsil.com*.

For HMO/CPO Coverage

- If you are already enrolled and only **changing** your provider or network selection, enter your Group and Member Identification numbers found on your BCBSIL ID card.
- Sign and date this form on page 2.

Employer Name _____ **Member ID Number** _____

Group/Section # _____ **Effective Date** _____

Employee Name (Last) _____ (First) _____ (MI) _____

Social Security Number: | Date of Birth: / /

Medical Group/IPA # __ __ __ Medical Group/IPA Name: _____

PCP # __ __ __ __ __ __ __ __ __ PCP Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

CPO Network # C O __ __ CPO Network Name: _____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

Social Security Number: | Date of Birth: / /

Medical Group/IPA # __ __ __ Medical Group/IPA Name: _____

PCP # __ __ __ __ __ __ __ __ __ PCP Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: _____ NPI # __ __ __ __ __ __ __ __ __ __

BlueCross BlueShield of Illinois

HMO/CPO Provider Selection
Enrollment and Change Form

Dependent Name (Last) ______________________ (First) ______________________ (MI) ________	
Social Security Number:	Date of Birth: / /
Medical Group/IPA # __ __ __ Medical Group/IPA Name: ______________________	
PCP # __ __ __ __ __ __ __ __ __ PCP Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	
WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	

Dependent Name (Last) ______________________ (First) ______________________ (MI) ________	
Social Security Number:	Date of Birth: / /
Medical Group/IPA # __ __ __ Medical Group/IPA Name: ______________________	
PCP # __ __ __ __ __ __ __ __ __ PCP Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	
WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	

Dependent Name (Last) ______________________ (First) ______________________ (MI) ________	
Social Security Number:	Date of Birth: / /
Medical Group/IPA # __ __ __ Medical Group/IPA Name: ______________________	
PCP # __ __ __ __ __ __ __ __ __ PCP Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	
WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	

Dependent Name (Last) ______________________ (First) ______________________ (MI) ________	
Social Security Number:	Date of Birth: / /
Medical Group/IPA # __ __ __ Medical Group/IPA Name: ______________________	
PCP # __ __ __ __ __ __ __ __ __ PCP Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	
WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name: ______________________ NPI # __ __ __ __ __ __ __ __ __ __	

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Employee Signature **Date**

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