EMPLOYER – COMPLETE SECTION ONE

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

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

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	Instructions
SECTION 2 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. **Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 2, 3, 5 (skip Section 5 if declining coverage), 9 and 10. In Section 5 include name, social security number and date of birth of individual(s) canceling.
SECTION 3 YOUR INFORMATION	Complete this section with details about yourself even if you are declining coverage.
SECTION 4 YOUR COVERAGE	Complete all portions related to the coverages for which you are applying.

SECTION 5 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 2 and check the "Other Change(s)" box; then, complete Sections 3, 4, 5 and 10. In Section 5, 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 2 and check the "Other Change(s)" box; then, complete Sections 3 and 10.
SECTION 6 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 Certification and Disabled Dependent Physician Certification document must be completed and submitted with this enrollment application, if applicable.
SECTION 7 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 8 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 9 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 9 and sign Section 10, 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 10 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.

ENROLLMENT APPLICATION/CHANGE FORM

LINCOLNWAY AREA AFFILIATION OF PARTICIPATING SCHOOL DISTRICTS: Account #014330

SECTION 1: TO BE COMPLETED BY EMPLOYER

Name of Employer/District:_SOWIC Employer EIN: 36-2829561

Employee's Name ____________________________________ Employee's Job Title_______________________

Group #____________________ Section # _______________________ Social Security #___________________________

Employment Date (MM/DD/YYYY) _________/_______/_________ Status Change Date:_______/____/________

Eligibility Status: ☐ Active Employee ☐ Retired Employee - Date of Retirement:___/___/____

SECTION 2: TO BE COMPLETED BY EMPLOYEE *(PLEASE PRINT LEGIBLY)*

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 3, 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)

☐ Other

☐ Court Order (provide court order or decree)

☐ Loss of Other Coverage

☐ Other (explain): _______________

Effective Date of Benefits: ____ / ____ / ____

☐ Cancel Enrollee Health

☐ **Cancel Dependent Health**

List names of those canceling in Section 5 below

Event:

☐ Divorce** ☐ Death

☐ Terminated Employment

☐ Other _________________

Indicate Event Date:

____ /____ /_____

SECTION 3: 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
Email Address:				Home/Cell Phone #		
☐ Male ☐ Female	On average, how many hours a week do you work? (Required) ________________			Business Phone #		

SECTION 4 — SELECT YOUR HEALTH COVERAGE

☐ PPO (Group #165622/Section 0054)

☐ HMO Illinois ($30 Co-pay – Plan 3 #H14365/Section 0022)

☐ HMO Illinois ($35 Co-pay – Plan 4 #B01776/Section 0022)

☐ HMO BLUE ADVANTAGE ($30 Co-pay – Plan 3 #B14366/Section 0022)

☐ HMO BLUE ADVANTAGE ($35 Co-pay – Plan 4 #B01776/Section 0022)

SECTION 5 — COVERAGE OPTIONS

PLEASE COPLETE 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 (M/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 or a child in suit for adoption? ☐ Yes ☐ No	If not your eligible natural child, stepchild, foster child, or child in suite for adoption, are your (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 or a child in suit for adoption? ☐ Yes ☐ No	If not your eligible natural child, stepchild, foster child, or child in suite for adoption, are your (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 or a child in suit for adoption? ☐ Yes ☐ No	If not your eligible natural child, stepchild, foster child, or child in suite for adoption, are your (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 6 — DISABLED DEPENDENT 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 y our employer's plan, please attach a completed Disabled Dependent Certification and the Disabled Dependent Physician Certification document.

SECTION 7 – OTHER COVERAGE INFORMATION

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/YYY)	Type of Policy ☐Employee Only ☐Employee/Spouse ☐Employee/Children ☐Family
Name of Policyholder		Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	Relationship to Applicant ☐ Self ☐ Spouse ☐ Dependent
Employer's Name		Employment Date	Health Group #	Health ID #

SECTION 8 — MEDICARE COVERAGE INFORMATION

Name of person covered	Medicare A (Hospital) Effective Date ________ End Date _______ Medicare B (Medical) Effective Date ________ End Date _______ Medicare D (Drug) Effective Date __________ End Date _______ Medicare D (Drug) Carrier: ________________________________	Medicare HIC# (From Medicare Card)

Please indicate reason for Medicare Eligibility: ☐ Entitled Age ☐Entitled Disability ☐End-Stage Renal Disease ☐Disability and Current Renal Disease

SECTION 9 — DECLINATION OF COVERAGE
COMPLETE IF YOU ARE DECLINIG 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**: ☐ Medicare ☐ Medicaid ☐ Other Group Health Coverage – Carrier:______________________________ ☐ Other Individual Health Coverage – Carrier: ___________________________ Other (explain) ____ ☐ I am not enrolled in any health insurance plan, but do not want this coverage

SECTION 10 - 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 Illinois. 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:______________

_

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 party to a civil union or domestic partnership (coverage subject to your employer's plan).*