BlueCross BlueShield of Illinois

The HMOs of Blue Cross and Blue Shield of Illinois

ENROLLMENT AND POLICY CHANGE FORM

Employer Only: Please complete the following information				
❑ Open Enrollment	❑ Timely Enrollment (New Hires)	❑ Special Enrollment (Family Status Change)	❑ Policy Change (Add Dependent see Section 5)	COBRA/IL Continuation-Effective Date Begin Date: MM / DD / YY End Date: MM / DD / YY
Group Number	Section Number	Coverage Effective Date		

HMO Network	**HMO Illinois** ☐ w/HCA (BlueEdge℠ HMO) **Blue Advantage HMO℠** ☐ w/HCA (BlueEdge℠ HMO) **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	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.

Section 1: Employee Information – Please complete this entire section.

You must indicate your network PCP, WPHCP (if applicable) and their contracting Medical Group (MG) name and number.

Social Security Number	Last Name	First Name			Middle Initial
Street Address		City		State	Zip
Are you ❑ Male ❑ Female	Date of Birth MM / DD / YY	Marital Status ❑ Married ❑ Not Married	Date of Hire MM / DD / YY	Home Phone	Cell Phone
Employment Status ❑ Active ❑ Retiree ❑ COBRA ❑ IL Continuation	Company Name	Payroll Location	Business Phone ( )		
Dental HMO Office ID# ____________	PCP's MG#	PCP's Medical Group Name	PCP's Name	PCP's Provider #	
	WPHCP's MG#	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #	

Section 2: Family Coverage Information – Complete this section if electing family coverage.

List all dependents including name, birth date, and social security number. Each family member may select a different contracting Medical Group (MG), PCP, and WPHCP. In the appropriate spaces below, please indicate the name and number of each dependent's contracting Medical Group, PCP and WPHCP. 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 elect HMO or BlueChoice Select coverage, your dependents must live within the defined service area.

❑ Spouse ❑ Domestic Partner	Date of Birth MM / DD / YY	Last Name (if different)	First Name	Social Security Number
Dental HMO Office ID# ____________	PCP's MG#	PCP's Medical Group Name	PCP's Name	PCP's Provider #
	WPHCP's MG#	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
❑ Daughter ❑ Son	Date of Birth MM / DD / YY	Last Name (if different)	First Name	Social Security Number
Dental HMO Office ID#	PCP's MG#	PCP's Medical Group Name	PCP's Name	PCP's Provider #
❑ Eligible Military Personnel	WPHCP's MG#	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
Address (if different)				
❑ Daughter ❑ Son	Date of Birth MM / DD / YY	Last Name (if different)	First Name	Social Security Number
Dental HMO Office ID#	PCP's MG#	PCP's Medical Group Name	PCP's Name	PCP's Provider #
❑ Eligible Military Personnel	WPHCP's MG#	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
Address (if different)				
❑ Daughter ❑ Son	Date of Birth MM / DD / YY	Last Name (if different)	First Name	Social Security Number
Dental HMO Office ID#	PCP's MG#	PCP's Medical Group Name	PCP's Name	PCP's Provider #
❑ Eligible Military Personnel	WPHCP's MG#	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
Address (if different)				

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*PLEASE PRINT — USE BALL POINT PEN ONLY — **PRESS HARD.***

Note: Please verify your PCP and (if applicable) WPHCP selection with your contracting Medical Group (MG) when you receive your HMO identification cards.

Section 3: Medicare Information – Are you, your spouse, or dependent(s) eligible for, or covered by Medicare? No Yes
If yes, please complete the section below for each individual eligible for, or covered by Medicare. If no, please go to Section 4.

Please check and list the individual(s) eligible for, or covered by, Medicare: ❑ Self ❑ Spouse ❑ Dependent(s)

Name:_____ Name:_____

If more than one two individual(s) are eligible for, or covered by Medicare, please list the name(s) on a separate, attached sheet of paper.

Helpful Hints for Completing:
HIC number is the Health Insurance Claim account number. This number can be found on the individual's Medicare Card.
ESRD is the date when the End Stage Renal Disease regular course of dialysis began.
Start Date is when the date the individual became eligible for Medicare.
End Date is the date Medicare entitlement ended.

HIC #	Medicare Part B	ESRD Dialysis	Disability
Medicare Part A Start Date: MM / DD / YY	Start Date: MM / DD / YY End Date: MM / DD / YY	Start Date: MM / DD / YY End Date: MM / DD / YY	Start Date: MM / DD / YY End Date: MM / DD / YY

Section 4: Other Group Health Insurance Information – Complete this section if you or any of your family members have other group health insurance

Insured's Name	Employed By	Birth Date MM / DD / YY	Policy Number

Insurance Company Name	Address	City	State	Zip

Section 5: Policy Change – Complete this section if you are changing information to your existing policy.

Check reason for adding dependents: ❑ Marriage ❑ Birth ❑ Adoption* ❑ Guardianship* Date of the event: MM / DD / YY
*Legal documentation required.
List added dependent(s) as listed in Section 2:

Name:_____ Name:_____

❑ List new name(s) as listed in Section 1 or 2:

Name:_____ Name:_____

❑ List dropped dependent(s) as listed in Section 2:

Name:_____ Name:_____

I represent that all information furnished by me on this application is true and complete to the best of my knowledge.

I understand that the services listed in the HMO certificate(s) will be available, subject to the Term and Conditions thereof, beginning with hospital admissions or medical care rendered, on or after the coverage date set by Blue Cross and Blue Shield of Illinois (BCBSIL).

I understand that BCBSIL use or disclosure of individually identifiable health information, whether furnished by me or obtained from other sources such as medical providers, shall be in accordance with the federal privacy regulations under HIPAA (Health Insurance Portability and Accountability Act of 1996).

I also authorize my employer/group to deduct from my pay and remit the prevailing fee that may be required for cost of said coverage. This authorization is to remain in effect until my employer/group is notified in writing to the contrary.

Signature of Applicant: _____ **Date Signed:** MM / DD / YY