ILLINOIS INSTITUTE OF TECHNOLOGY

BlueCross BlueShield of Illinois

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APPLICATION AND POLICY CHANGE

*PLEASE PRINT — USE BLACK BALLPOINT PEN ONLY — **PRESS HARD.***

① ENROLLEE: ☐ Timely Enrollment ☐ Special Enrollment ☐ Late Enrollment ☐ Open Enrollment ☐ Retiree ☐ Membership Change

② EFFECTIVE DATE:

③ ~~COBRA/ IL Continuation~~

FOR USE BY BCBSIL ONLY
REASON CODE: ____ ____

④ COVERAGE APPLIED FOR: Check all that apply.**

⑤ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

Medical

☑ In-Network PPO

CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
Date: / /	Date: / /	Date: / /	Date: / /
☐ Name	☐ Marriage	☐ Marriage	☐ Terminate Coverage
☐ Address	☐ Newborn	☐ Divorce	☐ Voluntary Withdrawal **
☐ Telephone	☐ Adoption/Placement	☐ Age Limit	☐ Leave/Layoff
☐ Reinstate	☐ Legal Guardianship	☐ Other:	☐ Out of Service Area Move
☐ Medicare Coverage	☐ Other:		☐ Other:

NOTE: Only list dependents to be added or dropped in the Family Coverage Information Section ⑦.

⑥ EMPLOYEE INFORMATION: Company Name: Illinois Institute of Technology

Last Name: | First Name: | Mid. Initial

Street Address: | Apt. No.: | City: | State: | Zip:

Date of Birth: ____/____/____ Gender: ☐ Male ☐ Female

Employee Social Security Number: ____ — ____ — ____ Employee Identification Number (if known): ____

Telephone No.: Bus.: (____) ____ Home: (____) ____ Date of Hire: ____/____/____

Are you covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**

HIC #: ____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

Ⓐ SPOUSE: Date of Birth: ____/____/____ Last Name (Only If Different): ____

First Name: ____ Social Security Number: ____ — ____ — ____

Is your spouse covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**

HIC #: ____	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

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Illinois Institute of Technology

BlueCross BlueShield of Illinois

EMPLOYEE INFORMATION: Company Name: Illinois Institute of Technology Group #:

Last Name: First Name: Mid. Initial

⑦ Ⓑ ☐ SON ☐ DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): ____________

First Name: ____________ Social Security Number: ______—______—______

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**

HIC #: ____________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

☐ SON ☐ DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): ____________

First Name: ____________ Social Security Number: ______—______—______

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**

HIC #: ____________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

☐ SON ☐ DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): ____________

First Name: ____________ Social Security Number: ______—______—______

Is this dependent covered under your employer's health care plan and also covered by Medicare? ☐ No ☐ Yes **If Yes, please complete the section below:**

HIC #: ____________	MEDICARE B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ____/____/____	Start Date: ____/____/____	Start Date: ____/____/____
Start Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____	End Date: ____/____/____

⑧ OTHER INSURANCE INFORMATION:

If you or any of your family members have OTHER GROUP COVERAGE, **CHECK all that apply.** ☐ Health: Policy #: ____________ ☐ Dental: Policy #: ____________

☐ Prescription Drug Coverage: Policy #: ____________ ☐ Vision: Policy #: ____________ ☐ Hearing: Policy #: ____________

If Yes: Is the other insurance: ☐ Single Coverage ☐ Family Coverage

EMPLOYED BY: ____________ Insured's Name: ____________ Date of Birth: ____/____/____

Insurance Company Name: ____________ Address: ____________

City: ____________ State: ______ Zip: ______ Telephone Number: ____________

⑨ FORT DEARBORN LIFE:

Must Complete Separate Beneficiary Form

⑩ **I APPLY FOR COVERAGE AS INDICATED ABOVE,** for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical, dental coverage and health maintenance coverage), and/or Fort Dearborn Life Insurance Company (providing the life and disability insurance) (the Company). I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit any required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Date Signed: ____/____/____ **Signature of Applicant:** ____________

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the Company.

Not enrolling for: ☐ Myself ☐ My spouse ☐ My spouse and dependents ☐ My dependents ☐ Myself, my spouse and my dependents

Date Signed: ____/____/____ **Signature of Applicant:** ____________