ILLINOIS INSTITUTE OF TECHNOLOGY

BlueCross BlueShield of Illinois

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 (017686)

☐ HDHP With HSA (059361)

☐ HDHP NO HSA (059383)

If electing HDHP with HSA please indicate your monthly contribution to your HSA. $ _____

Note: To make mid year changes to your HSA contributions, please use the appropriate form found on the MyIIT portal.

CHANGES

Date: / /

☐ Name
☐ Address
☐ Telephone
☐ Reinstate
☐ Medicare Coverage

ADD DEPENDENTS

Date: / /

☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: _____

CANCEL DEPENDENTS

Date: / /

☐ Marriage
☐ Divorce
☐ Age Limit
☐ Other: _____

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

CANCEL (Check all that apply)

Date: / /

☐ Terminate Coverage
☐ Voluntary Withdrawal**
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other: _____

(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.**

(A) 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: _____ / _____ / _____

Illinois Institute of Technology

BlueCross BlueShield of Illinois

EMPLOYEE INFORMATION: Company Name: Illinois Institute of Technolog Group #: ____

Last Name: ____ First Name: ____ Mid. Initial ____

(7) (B) ☐ **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:** ____