BlueCross BlueShield of Illinois

Applicant Name _____

SSN# _____

Member ID: _____

HOME OFFICE USE ONLY

Individual Plan

New Application or Change in Coverage

To help us process your application promptly, please remember to:

1. Print all answers in **blue or black ink**. Pencil will not be accepted.
2. Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.
3. If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.
4. Please do not use correction fluid or tape.

Please submit an application via one of the following methods. If submitting by mail or fax, please complete the entire application and select a premium mode in Section D.

If you are working with a Blue Cross and Blue Shield of Illinois Agent, please remember to include the name of your agent on the back of this application.

APPLY ONLINE	bcbsil.com
APPLY BY MAIL	Blue Cross and Blue Shield of Illinois - Attn: Individual Enrollment, P.O. Box 3236, Naperville, IL 60566–7236
APPLY VIA FAX	888-223-1988

If you have any questions, please call your agent or call toll-free at 800-477-2000.

Please answer the following questions only if you are applying for a Special Enrollment Period. You may request a Special Enrollment Period because you have experienced one or more of these events during the last 60 days (check all that apply). Note: if you are applying outside of Open Enrollment, you must have experienced one of the events below in order to apply.

☐ **1.** I and/or my dependent(s) lost minimum essential coverage[1]: ☐ Involuntary loss due to reasons other than non-payment of premium or rescission on: ☐ Due to reaching the maximum age, legal separation, divorce, or death of the policyholder, as of: ☐ I am no longer eligible for my prior health insurance plan due to termination of employment, reduction in number of hours of employment, loss of employer contribution toward my premiums, or I have exhausted my Cobra benefits as of: ☐ I am no longer residing or living in my prior health insurance plan's HMO service area as of: ☐ I have a claim that would meet or exceed a lifetime limit on all benefits as of: ☐ I have lost coverage because my plan no longer offers benefits to the class of similarly situated individuals as of: ☐ I have lost coverage through my group HMO because I no longer reside or work in the service area and no other package is available as of:	DATE OF EVENT
☐ **2.** I gained or became a dependent due to marriage on:	DATE OF EVENT
☐ **3.** I gained or became a dependent due to birth, adoption, or placement for adoption or foster care on:	DATE OF EVENT
☐ **4.** An error occurred in my previous health plan enrollment on, or I have adequately demonstrated that my previous health plan or issuer substantially violated a material provision of its contract with me, as of:	DATE OF EVENT
☐ **5.** The Health Insurance Marketplace has determined that I or my dependents are newly eligible or ineligible for payments of the advance premium tax credit, or have a change in cost-sharing eligibility, or misconduct by a non-marketplace entity as of:	DATE OF EVENT
☐ **6.** I gained access to new health plan options because of a permanent move on:	DATE OF EVENT
☐ **7.** My current policy is ending in a non-calendar year ending on[1]:	DATE OF EVENT
☐ **8.** Other qualifying event. If you do not see your circumstance listed, please work with your agent or contact our sales center at 800-477-2000.	DATE OF EVENT

[1]Can apply 60 days in advance.

Section A: Applicant(s)

Applicant Name _____

SSN# _____

PRIMARY APPLICANT

☐ NEW COVERAGE ☐ ADD DEPENDENT ☐ CHANGE IN COVERAGE ☐ TRANSFER AND CONVERSION

FIRST NAME, MIDDLE INITIAL, LAST NAME	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY.)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN
☐ CUBAN ☐ OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY.) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP	COUNTY

MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)

PRIMARY PHONE	CELL ☐ LANDLINE ☐	SECONDARY PHONE	CELL ☐ LANDLINE ☐

EMAIL ADDRESS	PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL

MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP # (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)†

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY.)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A
☐ PUERTO RICAN ☐ CUBAN ☐ OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY.) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS	PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL

MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP # (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N
IF YES, PLEASE SPECIFY:

***WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO** (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N
IF YES, PLEASE PROVIDE DATE OF LAST USE:

IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY.)
☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A
☐ PUERTO RICAN ☐ CUBAN ☐ OTHER_____

RACE (OPTIONAL—CHECK ALL THAT APPLY.) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO
☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER_____

*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)	COUNTY

PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS	PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL

MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP # (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:

* Age 18 and over
† The designation of spouse shall include domestic partners.
** Services must be provided by Primary Care Physician within the Medical Group selected.

Section A: Applicant(s) (Continued)

Applicant Name ______________________

SSN# ______________________

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY.) ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN ☐ CUBAN ☐ OTHER ________________		
RACE (OPTIONAL—CHECK ALL THAT APPLY.) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER________					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)				COUNTY	
PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS		PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL		
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP # (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:			

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY.) ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN ☐ CUBAN ☐ OTHER ________________		
RACE (OPTIONAL—CHECK ALL THAT APPLY.) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER________					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)				COUNTY	
PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS		PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL		
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP # (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:			

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX M F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? Y N IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO (4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES)? Y N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY.) ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN ☐ CUBAN ☐ OTHER ________________		
RACE (OPTIONAL—CHECK ALL THAT APPLY.) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER________					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)				COUNTY	
PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS		PREFERRED CONTACT METHOD ☐ EMAIL ☐ POSTAL MAIL		
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP # (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) Y N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:			

* Age 18 and over
† The designation of spouse shall include domestic partners.
**Services must be provided by Primary Care Physician within the Medical Group selected.

IF ANY OF THE TELEPHONE NUMBERS ABOVE ARE CELLULAR TELEPHONES THEN I AGREE TO THE FOLLOWING TYPES OF CONTACTS:
BCBSIL may call me or any one of my dependents with prerecorded or automated calls related to my health care coverage. Y N
BCBSIL may call me or any one of my dependents with information about new plans and benefits. Y N

IF ANY OF THE TELEPHONE NUMBERS ARE YOUR RESIDENTIAL (LAND LINE) THEN I AGREE TO THE FOLLOWING TYPE OF CONTACT:
BCBSIL may call me or any one of my dependents with information about new plans and benefits. Y N

Section B: Applying for Coverage

Applicant Name _____

SSN# _____

NOTE: Effective dates are available on the 1st of the month only, unless otherwise required by law. Applications must be received by Blue Cross and Blue Shield of Illinois within the defined enrollment period to be accepted.

PLAN SELECTION	DEDUCTIBLE
☐ Blue PPO Bronze℠ 005	$5,000
☐ Blue PPO Bronze℠ 006	$6,000
☐ Blue PPO Silver℠ 004	$3,000
☐ Blue PPO Silver℠ 003	$6,000
☐ Blue PPO Gold℠ 012	$1,000
☐ Blue PPO Gold℠ 002	$1,500
☐ Blue PPO Gold℠ 001	$3,250

PLAN SELECTION	DEDUCTIBLE
☐ Blue Choice Bronze PPO℠ 005	$5,000
☐ Blue Choice Bronze PPO℠ 006	$6,000
☐ Blue Choice Silver PPO℠ 004	$3,000
☐ Blue Choice Silver PPO℠ 003	$6,000
☐ Blue Choice Gold PPO℠ 007	$1,000
☐ Blue Choice Gold PPO℠ 002	$1,500
☐ Blue Choice Gold PPO℠ 001	$3,250

PLAN SELECTION	DEDUCTIBLE
☐ Blue Precision Platinum HMO℠ 004	$0
☐ Blue Precision Gold HMO℠ 001	$2,000
☐ Blue Precision Silver HMO℠ 002	$5,000
☐ Blue Precision Bronze HMO℠ 003	$6,000
☐ Blue Precision Gold HMO℠ 006	$0

For HMO Only: **ATTENTION FEMALE MEMBERS:** In selecting your Medical Group, remember that your Medical Group's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your Medical Group. However, if your Medical Group is part of a limited provider network (LPN), the OB/GYN from who you receive services must belong to the same LPN as your Medical Group. This is another reason to make certain that your Medical Group's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your Medical Group.

TRANSFER & CONVERSION PLAN	DEDUCTIBLE
☐ Blue PPO Gold ℠ 013	$1,000
☐ Blue Precision Gold HMO℠ 005	$2,000

Show your present Blue Cross and Blue Shield coverage numbers.

GROUP NUMBER:

CERTIFICATE NUMBER:

LOCATION OF BLUE CROSS AND BLUE SHIELD PLAN
(CITY/STATE)

The plan below covers essential health benefits, but only after out-of-pocket cost sharing reaches the high deductible/out-of-pocket maximum required by law.

Select this plan only if you are under 30 before the plan year begins, or have received a certification that you are exempt from the individual mandate because you do not have an affordable coverage option or because you qualify for a hardship exemption. Please enclose a copy of your certificate of exemption with your application.

☐ Blue Security PPO℠ 010	$6,600
☐ Blue Choice Security PPO℠ 008	$6,600

Section C: Dental Coverage

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this policy have coverage for pediatric dental services that are essential health benefits. The Affordable Care Act requires these benefits even if there is no one on the policy who is eligible for these services.

Carriers can offer this required pediatric dental coverage to you through benefit plans called "marketplace-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

There are three ways to meet this requirement.

1	You can enroll in **BlueCare Dental℠**, our Full Dental QHP, which contains coverage for adults and pediatric dental essential health benefits; or
2	You can enroll in **BlueCare Dental 4 Kids℠**, our Limited Dental QHP, which only contains pediatric dental essential health benefits; or
3	You can confirm that you have obtained coverage for pediatric dental essential health benefits somewhere else.

Please review your options below and select **one**:

If you do not select an option then you and each member on the policy will be enrolled in BlueCare Dental 4 Kids 1B, our Limited Dental QHP, in order to meet ACA's requirement that we provide you coverage with pediatric dental services that are essential health benefits.

BlueCare Dental (For All Applicants)	DEDUCTIBLE
☐ 1A	$50
☐ 1B	$75

BlueCare Dental 4 Kids℠ (For Child[ren] Applicants)	DEDUCTIBLE
☐ 1A	$50
☐ 1B	$75

NOTE: Dental plans include an additional premium. For premium information, please call 800-477-2000, or contact your authorized independent Blue Cross and Blue Shield of Illinois agent.

☐ **I/WE ALREADY HAVE THE NECESSARY COVERAGE** (I AND EACH APPLICANT LISTED ON THIS APPLICATION, ETC.) HAVE OBTAINED COVERAGE FOR PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS THROUGH ANOTHER POLICY.

DATE	SIGNATURE

Section D: Billing Information

Applicant Name _____

SSN# _____

Note: Do not cancel any current coverage you may have until your application is approved and your new plan is effective.

Please select one of the following options to make arrangements for paying your premium.

☐ BANK DRAFT

Bank Draft includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement below.

☐ 1-MONTH BANK DRAFT (12 Payments Per Year)

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only

I request and authorize Blue Cross and Blue Shield of Illinois (BCBSIL) and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer–sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the financial institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my financial institution I understand that I will need to provide at least 10 days advance notice to Blue Cross and Blue Shield of Illinois by telephone prior to a scheduled withdrawal date.

Please complete the following – print or type information

I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non–business day or a holiday, the premium payment will be deducted from my account on the next business day.

Please ensure adequate funds are available at the time of application. Blue Cross and Blue Shield of Illinois is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT	**NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT**
BANK TRANSIT NUMBER	**DEPOSITOR'S ACCOUNT NUMBER**

☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

DEPOSITOR'S SIGNATURE	**DATE**	**RELATIONSHIP TO APPLICANT**

☐ DIRECT BILLING OPTIONS

FIRST MONTH PREMIUM AMOUNT OF $ **ENCLOSED**

☐ SEND ME A BILL BY EMAIL ☐ SEND ME A PAPER BILL ☐ SEND ME A BILL BY MOBILE PHONE

☐ 1-MONTH DIRECT BILL (12 Payments Per Year) ☐ 2-MONTH DIRECT BILL (6 Payments Per Year) ☐ 3-MONTH DIRECT BILL (4 Payments Per Year)
☐ 6-MONTH DIRECT BILL (2 Payments Per Year) ☐ 12-MONTH DIRECT BILL (1 Payment Per Year)

NOTE: Cashing of the Premium Deposit does not constitute approval of this Application. If this Application is not approved, the Premium Deposit will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

☐ LIST BILL

LIST BILL (INDICATE NAME OF BILL-TO PARTY BELOW.)

EXISTING LIST BILL NUMBER

BILLING NAME AND ADDRESS

If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless requested otherwise.

FIRST NAME, MIDDLE INITIAL, LAST NAME

BILLING ADDRESS - STREET, CITY STATE, ZIP

NAME OF BILL-TO PARTY (IF REQUESTING LIST BILL ONLY)

Section E: Proxy Statement

Applicant Name _____

SSN# _____

PROXY STATEMENT

PROXY STATEMENT

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters (300 E. Randolph St., Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

PRIMARY APPLICANT'S PROXY SIGNATURE (OPTIONAL) YOU MUST ALSO SIGN IN "SECTION G" BELOW:	DATE

PRINT YOUR NAME AS YOU SIGNED IT:

Section F: Other Coverage Information

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE, OR DID THEY PREVIOUSLY HAVE **WITHIN THE LAST 5 YEARS**, BLUE CROSS AND BLUE SHIELD OF ILLINOIS COVERAGE, OR HEALTH OR MAJOR MEDICAL INSURANCE COVERAGE WITH ANY OTHER INSURER, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT? Y N **IF "YES", PLEASE COMPLETE THE FOLLOWING:**

APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)
APPLICANT NAME	**NAME ON PREVIOUS POLICY (IF APPLICABLE)**	**MEMBER/GROUP NUMBER (OPTIONAL)**

REPLACEMENT OF COVERAGE

WILL THIS INSURANCE REPLACE ANY HEALTH INSURANCE CURRENTLY IN FORCE? Y N

IF "YES," READ THE STATEMENT BELOW AND COMPLETE THE FOLLOWING:

LIST ALL COVERAGE THAT WILL BE REPLACED

INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Illinois. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning any person applying for coverage. Failure to include all material information on any application may provide a basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Illinois.

Section G: Required Signatures

Applicant Name _____

SSN# _____

ACKNOWLEDGMENTS

The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows:

1. This application is the first step in applying for Medical Expense Coverage. You do not have Medical Expense Coverage until the effective date of the policy and the first month's premium is paid.
2. If you use an agent or broker, they cannot accept risks or modify policies or requirements of the Company.
3. If a spouse and/or dependent(s) is/are included for medical expense coverage, the premium will be calculated based on the age of each individual covered, subject to applicable law and regulations.
4. I understand that any person who knowingly presents fraudulent claim for payment of a loss or benefit or fraudulently or intentionally misrepresents a material fact on the application may result in the coverage being rescinded. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.
5. If an Agent, Producer or a Broker was working with me to purchase an Individual Policy, then the Company may pay the broker a commission and/or other compensation. I understand that if I want additional information about any commissions or other compensation paid the agent or broker I should contact the agent or broker.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following payment in full of the first month's premium. The undersigned Applicant and broker acknowledge that the Applicant has read the completed application which will become a part of the contract between BCBSIL and the applicant.

Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the prescription and use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information. I understand that Blue Cross and Blue Shield of Illinois will only disclose collected information as needed to medical entities related to my care.

I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law. If such a disclosure is required, the person or agency receiving the information will become responsible for its protection.

This Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting Blue Cross and Blue Shield of Illinois. I further understand that I or any authorized representative will receive a copy of this authorization upon request. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

Signatures: I acknowledge receipt of the Required Outline of Coverage and I agree that Individual Insurance is intended to be paid as my personal expense. If a non-family member is paying all or part of my premium I also agree that the payment is in compliance with laws or regulations.

In addition I acknowledge that this coverage is intended to be individual coverage and nothing in this document creates a group health plan as defined under state and federal laws.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PRIMARY APPLICANT'S SIGNATURE	**DATE**
SPOUSE'S SIGNATURE (IF APPLYING)†	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	**DATE**
PARENT OR LEGAL GUARDIAN OF A MINOR CHILD	**DATE**
IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE, ON BEHALF OF AN INDIVIDUAL (OTHER THAN A PARENT FOR A MINOR CHILD), COMPLETE THE FOLLOWING:	
PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	**RELATIONSHIP:**

† The designation of spouse shall include domestic partners.

Section H: Agent Information

Applicant Name _____

SSN# _____

AGENT'S CERTIFICATION

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the Required Outline of Coverage, and if requested, the Disclosure Statement.

AGENT INFORMATION (if applicable)

AGENT'S SIGNATURE	DATE	AGENT ID	P&C CROSS REFERENCE
		045739000	
PRINT AGENT'S NAME Randal J. Sable	AGENT'S PHONE 847-905-1915		AGENT'S FAX 847-905-1915

THANK YOU FOR APPLYING.

Please include all necessary materials when submitting this application.

If legal guardian, please enclose signed court decree.