BlueCross BlueShield of Illinois

Fax Cover Letter

Please fax this application with cover letter to (847) 220-9280 or email to help@ihealthagents.com

Name: _____

Email: _____

Date: _____

☐ Please contact me by email to confirm my application
Email: _____

☐ Please contact me by phone to confirm my application
Phone Number: _____

BlueCross BlueShield of Illinois

Applicant Name _____

SSN# _____

2018 BlueCare Dental℠

New Application or Change in Coverage

HOME OFFICE USE ONLY

To help us process your Application promptly, follow the instructions.

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 your Application via mail or fax or by calling an agent of Blue Cross and Blue Shield of Illinois (BCBSIL) at 800-477-2000. Please complete the entire Application including the selection of a Payment/Billing Method in Sections D & E. Please note: If you are applying during a Special Enrollment Period (SEP), proof of a qualifying event must be included to complete your Application. Failure to provide appropriate SEP documentation will delay processing of the Application.

If you are working with a BCBSIL agent, please remember to include the name of your agent on the back of this Application.

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 BCBSIL toll-free at 800-477-2000.

If you are applying for coverage during a Special Enrollment Period or "SEP" (an opportunity to enroll outside of Open Enrollment). You may request coverage if you have experienced one or more of the qualifying life events listed below during the last 60 days (check all that apply). **You must provide acceptable proof of a qualifying event with this Application.** BCBSIL will review this proof to verify your eligibility for a SEP. Failure to provide acceptable proof with this Application of a qualifying event will delay or prevent the processing of your Application and enrollment in coverage. Please call your agent or BCBSIL at 800-477-2000 for examples of acceptable proof of these qualifying events.

☐ **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, or 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, placement for adoption, foster care or court-order on:	DATE OF EVENT
☐ **4.** An error occurred in my previous health plan enrollment, 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 am/are newly eligible or ineligible for payments of the advanced 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 on a date other than December 31st, which is:[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

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

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

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

† The designation of spouse shall include domestic partners.

Please Note: If adding new dependents to your policy, you still need to complete information for everyone on your policy.

BY PROVIDING AN EMAIL ADDRESS, YOU AGREE TO ELECTRONIC DELIVERY OF YOUR INSURANCE DOCUMENTS. You can go back to paper delivery at anytime with no penalty. To change or manage your preferences, log in to your account at bcbsil.com or call the customer service number on your ID card. Your documents can be viewed or printed using your computer or mobile device that supports most versions of Internet Explorer, Chrome and Firefox.

IF ANY OF THE TELEPHONE NUMBERS I PROVIDE IN THIS APPLICATION ARE CELL PHONES, 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 dental 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 I PROVIDE IN THIS APPLICATION ARE FOR RESIDENTIAL (LANDLINE) PHONES, 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

* Age 18 and over.

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

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

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

† The designation of spouse shall include domestic partners.

* Age 18 and over.

Section B: Applying for Coverage

NOTE: Effective dates are available on the 1st of the month only, unless otherwise required by law. Applications must be received by BCBSIL within the defined enrollment period to be accepted. **I acknowledge that I have reviewed the providers that are currently in the network for the plan I choose.**

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

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

Section C: Medical Coverage

Applicant Name _____

SSN# _____

OTHER COVERAGE INFORMATION

DO YOU CURRENTLY HAVE AN INDIVIDUAL BCBSIL POLICY? (NOT THROUGH YOUR EMPLOYER) Y N **IF "YES", PLEASE COMPLETE THE FOLLOWING:**	
PRIMARY APPLICANT	**MEMBER ID #**

Section D: Initial Premium Payment Information

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 Premium Payment options for your Application to be processed.

☐ BANK DRAFT

Payment will be drafted upon receipt of this Application. You must complete the Authorization Agreement below.

☐ ONE-TIME BANK DRAFT

AUTHORIZATION AGREEMENT

Required for Bank/Financial Institution Draft Payments Only

I request and authorize BCBSIL and/or its designee to obtain payment of monthly premium amounts becoming due on the last day of the month prior to the following month's coverage by initiating charges from my checking or savings 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 from my 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. If an ACH Transaction from my account is rejected for Non-Sufficient Funds (NSF), I understand that BCBSIL may at its discretion attempt to process the charge again within 30 days. I also understand that both the Financial Institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To change the Financial Institution these payments are paid from, I understand that I will need to provide at least 15 days advance notice to BCBSIL 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.

Please ensure adequate funds are available at the time of Application. BCBSIL 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**
NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED	
BANK TRANSIT NUMBER	**DEPOSITOR'S ACCOUNT NUMBER**

☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

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

☐ OTHER PAYMENT METHOD

FIRST MONTH PREMIUM AMOUNT OF $ _____ ENCLOSED

☐ CHECK ☐ MONEY ORDER

NOTE: Cashing of the Premium Payment does not constitute approval of this Application. If this Application is not approved, the Premium Payment 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.

Policy on third-party payments. BCBSIL only accepts premium and cost-sharing payments from: (1) the Applicant; (2) the Applicant's family; (3) Required Entities (the entities the law requires BCBSIL to accept premium and cost-sharing payments from, which currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make premium or cost-sharing assistance available to the Applicant: (a) for the entire coverage period of the Applicant's Contract, (b) regardless of the Applicant's health status, and (c) cannot condition assistance on enrollment with a particular issuer or in a particular benefit plan. BCBSIL does not accept premium and cost-sharing payments from any other third party. A violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to the Applicant's account or coverage, which may result in the termination or cancellation of coverage.

In addition, I understand that the coverage for which I am applying is not an employer-sponsored group dental insurance plan and is not intended, in any way, to be an employer-sponsored group dental insurance plan. I certify that my employer, if any, will not contribute any part of the premium, or provide reimbursement for any part of the premium for this coverage, now or in the future.

When you renew BCBSIL coverage or reenroll by selecting a new product, you will need to be current on your premium payments. Any past due premium payments for coverage we provided will be due at the beginning of the new plan year in addition to current premium charges. New coverage will not be effective until all such payments are made.

Section E: Ongoing 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.

BANK DRAFT

Payment will be drafted on the last business day of the month. You must complete the Authorization Agreement below.

☐ MONTHLY BANK DRAFT

AUTHORIZATION AGREEMENT

Required for Bank/Financial Institution Draft Payments Only

I request and authorize BCBSIL and/or its designee to obtain payment of monthly premium amounts becoming due on the last day of the month prior to the following month's coverage by initiating charges from my checking or savings 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 from my 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. If an ACH Transaction from my account is rejected for Non-Sufficient Funds (NSF), I understand that BCBSIL may at its discretion attempt to process the charge again within 30 days. I also understand that both the Financial Institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To change the Financial Institution these payments are paid from, I understand that I will need to provide at least 15 days advance notice to BCBSIL 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. I certify that I am an authorized user of this checking or savings account and will not dispute these scheduled transactions with my Financial Institution so long as the transactions correspond to the terms indicated in this authorization agreement.

Please ensure adequate funds are available at the time of Application. BCBSIL 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**

NAME AND LOCATION OF BANK WHERE ACCOUNT IS AUTHORIZED

BANK TRANSIT NUMBER	**DEPOSITOR'S ACCOUNT NUMBER**

☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT

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

DIRECT BILLING

☐ MONTHLY PAPER BILL	☐ MONTHLY PAPERLESS BILL	EMAIL ADDRESS:

NOTE: Cashing of the Premium Payment does not constitute approval of this Application. If this Application is not approved, the Premium Payment 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.

Policy on third-party payments. BCBSIL only accepts premium and cost-sharing payments from: (1) the Applicant; (2) the Applicant's family; (3) Required Entities (the entities the law requires BCBSIL to accept premium and cost-sharing payments from, which currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make premium or cost-sharing assistance available to the Applicant: (a) for the entire coverage period of the Applicant's Contract, (b) regardless of the Applicant's health status, and (c) cannot condition assistance on enrollment with a particular issuer or in a particular benefit plan. BCBSIL does not accept premium and cost-sharing payments from any other third party. A violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to the Applicant's account or coverage, which may result in the termination or cancellation of coverage.

In addition, I understand that the coverage for which I am applying is not an employer-sponsored group dental insurance plan and is not intended, in any way, to be an employer-sponsored group dental insurance plan. I certify that my employer, if any, will not contribute any part of the premium, or provide reimbursement for any part of the premium for this coverage, now or in the future.

Section F: Proxy Statement

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".**	**DATE**

PRINT YOUR NAME AS YOU SIGNED IT:

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 not coverage. Dental Expense Coverage will not begin until the effective date of the policy and the first month's premium is paid.
2. If I use an agent or broker, they cannot accept risks or modify policies or requirements of BCBSIL.
3. My premium, and that of my spouse and/or dependent(s), if any, will be calculated in accordance with applicable law and regulations.
4. I understand that if any person, on my behalf or on behalf of my spouse or other dependents, knowingly presents a fraudulent claim for payment of a loss or benefit or fraudulently misstates a material fact on this Application, coverage may be rescinded. A rescission of coverage is a cancellation or discontinuance of coverage that has a retroactive effect, canceling the coverage back to the first day it became effective. I understand that I will be provided with at least 30 days advance written notice before my coverage, or that of my spouse or other dependents, is rescinded.
5. If an Agent, Producer or Broker was working with me to purchase an Individual Policy, then BCBSIL 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 constitute 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 and understands the Application which will become a part of the contract between BCBSIL and the Applicant. To the best of my information, knowledge and belief the statements and answers on this Application are true, accurate and complete.

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 BCBSIL 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 BCBSIL to review and research its own records for information. I understand that BCBSIL 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 BCBSIL 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 BCBSIL. 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 BCBSIL prior to the date such revocation is received by BCBSIL.

Signatures: I acknowledge receipt of the required Schedule of Benefits and I agree that this Individual Plan is intended to be paid as my personal expense and that this Plan is offered on my representation that only I, a family member, or permissible third party as outlined in the Application will pay BCBSIL directly. I understand that BCBSIL does not accept payments of premium or cost-sharing payments directly from third parties except from those identified in Section D (family members, Required Entities, certain private non-profit foundations). I understand that a violation of these terms may result in premium and cost-sharing payments paid by a third party not being credited to my account or coverage or being refunded to me, which may result in the cancellation of my coverage for nonpayment of premium.

Special Enrollment Period Attestation and Acknowledgment: I understand that if I am applying for coverage outside of Open Enrollment, I must qualify for a Special Enrollment Period ("SEP"). I understand that in order to qualify for a SEP I must have experienced a qualifying event during the last 60 days, and I must provide acceptable proof of any qualifying event(s) with this Application in order for BCBSIL to verify my eligibility.

I represent that the proof I am providing is valid and I understand that failure to provide proof of a qualifying event will delay or prevent the processing of my Application and enrollment in coverage.

In addition I acknowledge that this coverage is intended to be individual coverage and nothing in this document creates a group dental 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**
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:**
DO YOU AUTHORIZE YOUR SPOUSE OR ADULT DEPENDENT(S) TO PROVIDE ADDITIONAL INFORMATION IF THE APPLICATION IS DEEMED INCOMPLETE? Y N	

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
PRINT AGENT'S NAME	AGENT'S PHONE		AGENT'S FAX
AGENT'S EMAIL			

Thank you for applying.

Please include all necessary materials when submitting this Application. If legal guardian, please enclose signed court decree. Visit **bcbsil.com/member** and click on **What to Expect** for frequently asked questions about membership, payments, and benefits.