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#: _____

Member ID: _____

Home Office Use Only

Sign Up for a **2019 Health Plan** for You and Your Family.

You can visit **bcbsil.com** to sign up. If you are working with a Blue Cross and Blue Shield of Illinois (BCBSIL) agent, be sure to include your agent's information on the final page.

TO HELP US PROCESS YOUR APPLICATION MORE QUICKLY, BE SURE TO:

- Answer **all** questions that apply to you.
- Answer **all** questions about legal dependents you are signing up.
- Include the first month's payment.
- Include details for how you want to make monthly payments.
- Sign the Application.
- Print all answers in **blue or black ink**. Pencil will not be accepted.
- **If you need to change any answers,** cross out what you are changing and add your initials by the new answer. Do not use correction fluid or tape.

HOW MAY WE CONTACT YOU?

If you want to get information from us electronically, we **must** have your email address. **By listing an email address, you agree we may send your policy information electronically.** This electronic delivery will continue through any policy renewals or changes.

You can go back to paper delivery at any time with no penalty. To make or change your choices, you may:

- Register for or log in to your account at **bcbsil.com**. Go to the top of the page and select Settings and then Preferences.

OR

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Internet Explorer, Chrome or Firefox.

If any of the phone numbers I list in this form is a mobile phone, I agree that:	BCBSIL may call me or any dependents 18 years old or over with prerecorded or automated calls related to my health care coverage.	☐ Y ☐ N
	BCBSIL may call me or any dependents 18 years old or over with information about new plans and benefits.	☐ Y ☐ N

If any of the phone numbers I list in this form is for a home (landline) phone, I agree that:	BCBSIL may call me or any dependents 18 years old or over with information about new plans and benefits.	☐ Y ☐ N

WHAT DO YOU WANT TO DO?

☐ Become a **NEW** BCBSIL member.

☐ **CHANGE** my 2019 BCBSIL health plan.

☐ **ADD** a dependent to my current BCBSIL health plan.[1]

[1] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**

Tell us about you.

Applicant Name: _____

SSN#: _____

(PLEASE ANSWER FOR **EACH** PERSON.)

PRIMARY APPLICANT (Who should be listed first on the health plan?)

First Name, Middle Initial, Last Name	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N If YES, what language?

Do you prefer to read or write a language other than English? Y N If YES, what language?

Within the past six months, have you used tobacco?[1]
4 or more times per week on average, excluding religious or ceremonial uses Y N
If YES, when did you last use tobacco?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano
☐ Puerto Rican ☐ Cuban ☐ Other _____

Are you or do you identify as (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 _____

Home Address - Street, City, State, ZIP Code | **County**

Mailing Address (IF YOU GET YOUR MAIL ELSEWHERE, LIKE A P.O. BOX)

What is the best phone number to reach you? ☐ Mobile ☐ Landline

Email Address[2]

Participating Medical Group[3] **(FOR HMO ONLY)**

Medical Group # (FOR HMO ONLY)

Do you have a disability that makes it hard to read, write or speak? (REQUIRED) Y N

If YES, tell us the best way to ask and answer questions with you:

SPOUSE OR DEPENDENT CHILD[4,5,6] (Who else do you want to be covered on your plan?)

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N
If YES, what language?

Within the past six months, have you used tobacco?[1]
4 or more times per week on average, excluding religious or ceremonial uses
Y N If YES, when did you last use tobacco?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

Are you or do you identify as (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[1] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you? ☐ Mobile ☐ Landline

Email Address[2]

Participating Medical Group[3] **(FOR HMO ONLY)**

Medical Group # (FOR HMO ONLY)

Do you have a disability that makes it hard to read, write or speak? (REQUIRED) Y N

If YES, tell us the best way to ask and answer questions with you:

[1] Age 18 and older.
[2] If you want to get information from us electronically, we **must** have your email address.
[3] Services must be provided by Primary Care Physician within the Medical Group selected.
[4] "Spouse" includes domestic partners.
[5] Up to age 26 unless medically disabled. Up to age 30 for unmarried military veterans.
[6] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**

Tell us about you. (**DEPENDENTS**[1], continued)

Applicant Name: _____

SSN#: _____

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N

If YES, what language?

Within the past six months, have you used tobacco?[2]
4 or more times per week on average, excluding religious or ceremonial uses

Y N If YES, when did you last use tobacco?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

Are you or do you identify as (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[1] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you?
☐ Mobile ☐ Landline

Email Address[3]

Participating Medical Group[4] **(FOR HMO ONLY)**

Medical Group # (FOR HMO ONLY)

Do you have a disability that makes it hard to read, write or speak? (REQUIRED) Y N

If YES, tell us the best way to ask and answer questions with you:

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

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If YES, what language?

Within the past six months, have you used tobacco?[2]
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☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Mailing Address[1] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you?
☐ Mobile ☐ Landline

Email Address[3]

Participating Medical Group[4] **(FOR HMO ONLY)**

Medical Group # (FOR HMO ONLY)

Do you have a disability that makes it hard to read, write or speak? (REQUIRED) Y N

If YES, tell us the best way to ask and answer questions with you:

[1] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**

[2] Age 18 and older.

[3] If you want to get information from us electronically, we **must** have your email address.

[4] Services must be provided by Primary Care Physician within the Medical Group selected.

Tell us about you. (**DEPENDENTS**[1], continued)

Applicant Name: _____

SSN#: _____

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N

If YES, what language?

Within the past six months, have you used tobacco?[2]
4 or more times per week on average, excluding religious or ceremonial uses

Y N If YES, when did you last use tobacco?

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☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Other Asian ☐ Native Hawaiian
☐ Guamanian or Chamorro ☐ Samoan ☐ Other Pacific Islander ☐ Other _____

Mailing Address[1] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you?
☐ Mobile ☐ Landline

Email Address[3]

Participating Medical Group[4] **(FOR HMO ONLY)**

Medical Group # (FOR HMO ONLY)

Do you have a disability that makes it hard to read, write or speak? (REQUIRED) Y N

If YES, tell us the best way to ask and answer questions with you:

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N

If YES, what language?

Within the past six months, have you used tobacco?[2]
4 or more times per week on average, excluding religious or ceremonial uses

Y N If YES, when did you last use tobacco?

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☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

Are you or do you identify as (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[1] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you?
☐ Mobile ☐ Landline

Email Address[3]

Participating Medical Group[4] **(FOR HMO ONLY)**

Medical Group # (FOR HMO ONLY)

Do you have a disability that makes it hard to read, write or speak? (REQUIRED) Y N

If YES, tell us the best way to ask and answer questions with you:

[1] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**

[2] Age 18 and older.

[3] If you want to get information from us electronically, we **must** have your email address.

[4] Services must be provided by Primary Care Physician within the Medical Group selected.

Signing up outside of Open Enrollment?

Applicant Name: _____

SSN#: _____

NOTE: If you are signing up during Open Enrollment, you may skip this page.

DO YOU QUALIFY FOR SPECIAL ENROLLMENT?

You may sign up for coverage during a Special Enrollment Period (SEP). An SEP is a chance to sign up outside of Open Enrollment.

- You must apply within 60 days before or after the qualifying life event.
- Check more than one event if more than one happened to you.
- **You must give us approved proof of a qualifying event with this application.**
- BCBSIL will review this proof to confirm that you qualify for an SEP.
- Without proof, we cannot process your form or sign you up for a health or dental plan.
- Once your policy has been issued, your SEP cannot be re-used to apply for a different plan.

Please contact your independent, authorized agent or call BCBSIL at 800-477-2000 for examples of proofs we can accept. Details about documents you need to provide are at **bcbsil.com** on the Special Enrollment page.

☐ **1.** I and/or my dependent(s) lost Minimum Essential Coverage that met the requirements of ACA:[1]	Date(s) of **Event(s)**
☐ **a.** For reasons beyond my control (not including reasons like failure to pay my full premium or any disregard on my part for the plan's rules) as of this date.	**a.** _____
☐ **b.** Because someone on the plan turned age 26 or 30 if unmarried military veteran, or was legally separated or divorced as of this date.	**b.** _____
☐ **c.** Because the policyholder died as of this date.	**c.** _____
☐ **d.** Because I lost coverage because I lost my job, I lost hours, my employer stopped making payments, or my COBRA benefits ended as of this date.	**d.** _____
☐ **e.** Because I moved away from my HMO plan's service area as of this date.	**e.** _____
☐ **f.** Because I have a claim that would meet or go over a lifetime limit on all benefits as of this date.	**f.** _____
☐ **g.** Because I lost coverage when my plan stopped covering people in my situation as of this date.	**g.** _____
☐ **h.** Because I moved out of the service area and lost my group HMO coverage, and there were no other options with the group, as of this date.	**h.** _____
☐ **2.** Because I got married on this date.	Date of **Event**
☐ **3.** Because I had a baby, adopted a child, had a child placed with me for adoption, took in a foster child or was otherwise ordered to cover a dependent through a court order as of this date.	Date of **Event**
☐ **4.** Because there was a mistake when I signed up for my last health plan, or I have shown proof that my previous health plan or issuer broke its contract with me as of this date.	Date of **Event**
☐ **5.** Because someone on my plan had a change in income and doesn't qualify for the advance payment of premium tax credit or cost-sharing reductions, or my last non-Marketplace plan broke government rules as of this date.[1]	Date of **Event**
☐ **6.** Because I got new health plan options when I moved on this date.	Date of **Event**
☐ **7.** Because my current policy ends on a date other than December 31, which is this date.[1]	Date of **Event**
☐ **8.** Because of an allowed reason I do not see on this list that happened on this date. (Please work with your agent or contact our sales center at 800-477-2000.)[1]	Date of **Event**

[1] You must apply within 60 days before or after the qualifying life event.

Choose your health plan.

Applicant Name: _____

SSN#: _____

NOTE: Your coverage will start on the 1st of the month, unless otherwise required by law. Applications must be received by BCBSIL within the defined enrollment period to be accepted. I agree that I have checked to see that my providers are in the network for the plan I choose.

Please review your options below and **SELECT ONLY ONE OPTION:**

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
☐ **BlueCare Direct Silver℠ 212, in collaboration with Advocate Health Care**	$2,500
☐ **Blue Choice Preferred Bronze PPO℠ 201 - Two $40 PCP Visits**	$6,000
☐ **Blue Choice Preferred Bronze PPO℠ 202**	$3,150
☐ **Blue Choice Preferred Bronze PPO℠ 302**	$6,000
☐ **Blue Choice Preferred Silver PPO℠ 203**	$2,200
☐ **Blue Choice Preferred Silver PPO℠ 303**	$2,200
☐ **Blue Choice Preferred Gold PPO℠ 204**	$750
☐ **Blue FocusCare Bronze℠ 209**	$6,000
☐ **Blue FocusCare Silver℠ 210**	$4,150
☐ **Blue FocusCare Gold℠ 211**	$500
☐ **Blue Precision Bronze HMO℠ 205**	$6,000
☐ **Blue Precision Silver HMO℠ 206**	$2,500
☐ **Blue Precision Silver HMO℠ 306**	$2,600
☐ **Blue Precision Gold HMO℠ 207**	$500

CHOOSING THE "CATASTROPHIC" PLAN?

Here's what that means.

This plan covers essential health benefits, but only after you pay the high deductible or the out-of-pocket maximum amount. Choose this plan only if:

1) you are under age 30 before the plan year begins, **or**
2) you have a waiver from the Health Insurance Marketplace. Your Exemption Certificate Number is required to process your form.

☐ **Blue Choice Preferred Security PPO℠ 200**	$7,900

CONVERSION PLAN

☐ **Blue Precision Gold HMO℠ 208**	$3,250

Show your present Blue Cross and Blue Shield coverage numbers.

Group number:	**Certificate number:**

Location of Blue Cross And Blue Shield Plan (CITY/STATE):

OB-GYN ACCESS

You may get OB-GYN services from:

1) your Primary Care Provider (PCP), **or**
2) an OB-GYN. You do not need a referral from your PCP to see an OB-GYN. You do not have to tell us your choice of OB-GYN before a visit. **NOTE:** Some plans will cover your OB-GYN visits only if your OB-GYN is in your plan network.

Choose your dental plan.

Applicant Name: _____

SSN#: _____

The Affordable Care Act ("ACA") requires that we seek reasonable assurance from you that you and each individual on the policy to be issued to you have for pediatric dental services. The ACA considers coverage for pediatric dental services to be an essential health benefit that every policy must provide, even if there is no one on the policy who is eligible to utilize the coverage.

Companies like BCBSIL can offer this dental coverage for children through "Marketplace-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

There are three ways to follow this requirement:

1	You can sign up for BlueCare Dental℠, our Full Dental QHP. This covers adults and children; or
2	You can sign up for BlueCare Dental 4 Kids℠, our Limited Dental QHP. This covers pediatric dental services only; or
3	You can tell us that you have pediatric dental essential health benefits from another carrier.

Please review your options below and **SELECT ONLY ONE OPTION:**

BlueCare Dental (Covers Adults and Children)	INDIVIDUAL DEDUCTIBLE
☐ 1A	$50
☐ 1B	$75

BlueCare Dental 4 Kids (Covers Child[ren] Only)	INDIVIDUAL DEDUCTIBLE
☐ 1A	$50
☐ 1B	$75

If you don't buy a separate BCBSIL dental plan:

Check the box and sign here to tell us if you have what is known as an "exchange-certified stand-alone dental plan." Our records will show that you have the Pediatric Dental EHB from BCBSIL or another company.

☐ **I/we already have coverage for pediatric dental essential health benefits through another policy.**	
Signature	**Date**

NOTE:

If you do not make a choice, you and each member on the policy will be signed up for **BlueCare Dental 4 Kids 1B**, our Limited Dental QHP so you will have the required pediatric dental benefits.

BCBSIL may find that pediatric dental coverage must be included with your health care coverage by law. In that case, you may owe an additional monthly payment for pediatric dental benefits. This added amount will be included in your monthly bill.

Important billing rules.

Applicant Name: _____

SSN#: _____

ELECTRONIC FUNDS TRANSFER (EFT) BILLING RULES

If you allow EFT, you understand and agree that BCBSIL and/or the company BCBSIL chooses to process payments may withdraw monthly payments from your checking or savings account in accordance with the terms below:

- Payments are due on the last day of the month before the month of coverage.
- Payment will be made as you choose on the next page.
- Your bank or credit union will process these payments.
- If the payment date falls on a nonbusiness day or a holiday, the payment will be taken on the next business day.
- Please make sure you have enough money in your account when you submit this Application. If a payment is denied for non-sufficient funds (NSF), BCBSIL may try to process the charge again at any time in the next 30 days. BCBSIL will not pay you back for any fees your bank or credit union charges you for not having enough money in your account.
- Both the bank or credit union and BCBSIL reserve the right to end this payment program or your participation in it if payment is denied for NSF. This means payments would not be made automatically anymore. Coverage may stop (claims would not be paid) if you do not pay your monthly bill.
- To change the bank or credit union these payments are paid from, you will need to give at least 15 days' notice to BCBSIL by telephone before a scheduled payment date.

THIRD PARTY PAYMENT RULES

BCBSIL accepts premium or cost-sharing payments for members from these four sources only:

1. You

2. Your family, or someone who has your Power of Attorney, a Legal Guardian or a Trust

3. Authorized Entities
Under the law, BCBSIL accepts payments from Authorized Entities. At this time, Authorized Entities include:
a. Ryan White HIV/AIDS programs, under Title XXVI of the Public Health Service Act
b. Indian tribes, tribal organizations and urban Indian organizations
c. State and Federal government programs as described in 45 C.F.R. § 156.1250.

4. Private nonprofit foundations that pay:
a. for the entire coverage period of your contract,
b. no matter your health status, and
c. no matter what company or benefit plan you choose

Payments made by a third party that is not shown above will not be accepted for your account. This may end or cancel the coverage.

I understand:
- My BCBSIL plan will not be a group health plan sponsored by an employer.
- This coverage is not meant to be an employer-sponsored group health insurance plan in any way.

I agree:
- My employer (if any) will not pay any part of my monthly bill or copays.
- My employer (if any) will not pay me back for these payments now or in the future.

PAST DUE PAYMENT POLICY

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

Tell us how you will make your payments.

Applicant Name: _____

SSN#: _____

Please be sure to read the important billing rules on the previous page.
Your plan may be canceled if you don't make a payment.

FIRST PAYMENT

You may make your **first payment** by Electronic Funds Transfer (EFT), check or money order. Select your choice:

☐ EFT (Payment will be taken from your account immediately.) ☐ Check ☐ Money order

First month premium payment information (if paying by EFT):		
Please check one ☐ Checking Account ☐ Savings Account	**Name of depositor(s) if other than the Applicant**	
Bank routing number	**Depositor's account number**	
☐ **I have read and accept the below agreement**		
Depositor's signature	**Date**	**Relationship to Applicant**

First month premium payment enclosed (if not paying by EFT):

☐ Check ☐ Money Order

MONTHLY PAYMENTS

You may make your **monthly payments** by Electronic Funds Transfer, or we can send you a bill by email or mail. Select your choice:

☐ EFT ☐ Bill by email[1] ☐ Bill by mail

Monthly premium payment information (if paying by EFT, if different from above):		
Please check one ☐ Checking Account ☐ Savings Account	**Name of depositor(s) if other than the Applicant**	
Bank routing number	**Depositor's account number**	
☐ **I have read and accept the below agreement**		
Depositor's signature	**Date**	**Relationship to Applicant**

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, sharedrafts, or electronic debit entries, and I request and authorize the Financial Institution named here to accept and honor the same from my account.

NOTE:

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

Your first month's payment is due when you sign up. If you are signing up for a new plan, your application will not be processed until we receive your payment.

[1] If you want to get information from us electronically, we **must** have your email address.

Proxy statement (OPTIONAL)

Applicant Name: _____

SSN#: _____

By purchasing a BCBSIL health plan, I become a member of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). By signing this application, I ask the Board of Directors of HCSC to act on my behalf at all meetings of members of HCSC. I understand that:

- This permission will apply to any company that replaces HCSC
- The Board of Directors may appoint someone to vote for me

The annual meeting of members is scheduled to take place 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 if needed. Notice of any special meeting will be given within 30-60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

Primary Applicant's (your) proxy signature: **NOTE:** Whether you sign for proxy or not, you must sign on page 12 to complete this application.	**Date**
Print your name as you signed it:	

Tell us about any other coverage.

OTHER COVERAGE

Does any person applying for coverage currently have, or did they previously have within the last 60 days: • BCBSIL coverage? • Health coverage with any other insurer? • Coverage under a tax-supported or government program, including Medicare? **If yes, please provide details below:**	☐ Y ☐ N

Applicant Name	**Name on Previous Policy** (if applicable)	**Member/Group ID** (recommended)
Applicant Name	**Name on Previous Policy** (if applicable)	**Member/Group ID** (recommended)

REPLACEMENT COVERAGE

Will this plan replace any 2019 health coverage you already have? **If yes, read the statement below and list all coverage that will be replaced:**	☐ Y ☐ N

COVERED PERSON(S)	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE

If you chose "Yes" above, you plan to cancel your current accident and health plan and replace it with a BCBSIL plan. For your own information and protection, you should know how this decision may affect the coverage available to you in a new plan.

1. You may want to ask the company that offers the plan you are replacing about your decision. You could also talk to their agent. This is your right. It is in your best interest. You should be sure you understand all the issues you may have if you replace the coverage you have now.
2. If you still wish to cancel your present plan and replace it with new coverage, be sure to truthfully and completely answer all questions on this Application about any person applying for coverage. If you leave out any important information, BCBSIL may have a legal basis to deny any future claims and to refund your premium as though your contract had never been in force. Before you sign the completed Application, re-read it carefully to be sure that all information is correct.

Please read and sign below.

Applicant Name: _____

SSN#: _____

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE FOLLOWING:

- This Application is not coverage. Coverage will not begin until (1) the effective date of the policy and (2) the first month's payment is made.
- If I use an agent or broker, they cannot accept risks or change BCBSIL policies or rules.
- If an agent, producer or broker was helping me to purchase an individual or family health or dental plan, BCBSIL may pay the broker a commission and/or other payment. If I want more detail about any payment to the agent or broker, I should ask the agent or broker.
- If any person knowingly submits a false claim for payment of a loss or benefit or falsely misstates an important fact on this Application, coverage may be rescinded. This includes false claims or facts about me or any of my dependents. Rescission cancels the coverage back to the first day it became effective. I will be given at least 30 days' written notice before my coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the State's Department of Insurance and other applicable State and Federal laws and regulations. Rates are calculated based on age, tobacco use and geographic rating factors. These factors are also used to calculate premiums for any dependents covered on my policy.
- Coverage will start on the plan effective date only if the first monthly payment is received in full before that date.
- I allow any of the following people or organizations to share my health information with BCBSIL or their authorized representative:
  - Health professionals, hospitals, or clinics
  - Other health or health-related facilities
  - Government agencies
  - Pharmacy benefit managers, clearinghouses, or retail stores
  - Any other persons or firms required by law

  – This information may include:
  - Copies of records about advice, care or treatment that were given to me and/or my dependents
  - Information about the prescription and use of drugs or alcohol (without limitation)
  - Information about mental illness
- BCBSIL may review and research its own records for information.
- BCBSIL will share collected information only as needed with medical entities to help manage my care.
- Information shared with my authorization may be re-shared by BCBSIL as allowed or required by law. If such sharing is required, the person or agency getting the information will be responsible for protecting it.
- This authorization is valid for two years from today, or until I cancel coverage.
  – I have the right to cancel the authorization at any time, in writing, by contacting BCBSIL.
  – I or anyone I authorize to represent me will receive a copy of this authorization upon request.
  – Any cancellation will not affect the activities of BCBSIL before the date such cancellation is received by BCBSIL.
- I present any statements and answers on this Application as FACTS. To the best of my knowledge and belief, they are true and complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSIL and me.
- My agent (if I have one) and I confirm that I have read and understood the Application.
- I have reviewed the details of the plan I chose.
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Application will pay BCBSIL directly.
- BCBSIL does not accept payments directly from third parties except from those listed on page 8 (family members, Required Entities, certain private nonprofit foundations).
- If these rules are broken, any payments made by a third party will not be credited to my account or coverage. These payments may not be refunded to me. This may result in the cancellation of my coverage for nonpayment.

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 MAY BE FOUND GUILTY OF A FELONY IN A COURT OF LAW.

Please read and sign below.

Applicant Name: _____

SSN#: _____

YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PROCESSED	
Primary Applicant's Signature	**Date**
Parent or Legal Guardian of a Minor Child (if child is the Primary Applicant)	**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 permit any other adult named on this form to answer questions about this form? ☐ Y ☐ N	

Did you work with an agent?

AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given.
- I provided written material to explain the benefits to the Applicant(s). This includes details about what may not be covered and any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes the Disclosure Statement(s) when requested.

Agent's Signature	**Date**	**Agent ID**
		00628138
Print Agent's Name RYAN KENNELLY	**Agent's Phone** 312-588-9915	
Agent's Email ryan@ilhealthagents.com		

Send us your Application.

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSSIBLE, DON'T FORGET TO:

- Sign your form.
- Send all pages of the form, even if some are blank.
- If you are working with a BCBSIL agent, please include your agent's information above.

SEND BY MAIL	Blue Cross and Blue Shield of Illinois Attn: Individual Enrollment, P.O. Box 3236, Naperville, IL 60566-7236
SEND BY FAX	888-223-1988
QUESTIONS?	If you have any questions, please call your agent or call BCBSIL toll-free at 800-477-2000.

Please include all necessary materials when submitting this Application.

If legal guardian, please enclose signed court decree. Visit **bcbsil.com/member** for frequently asked questions about membership, payments, and benefits and to track your application.