BlueCross BlueShield of Illinois

Dearborn National*

ENROLLMENT APPLICATION AND POLICY CHANGE

New Enrollment: **Open Enrollment:**

Effective Date of Benefits:

Name:

COVERAGE APPLIED FOR: Check all that apply

[ ] Medical Plan PPO #1 BCBS Group Number 230520
$0 Deductible Plan

[ ] Medical Plan PPO #2 BCBS Group Number 230521
$500 Deductible Plan

[ ] Waived Coverage

[ ] Dental Plan BCBS Group Number 230522

20005.1216

EMPLOYEE INFORMATION:	Company Name: Pekin Public Schools District 108	Account#: 230519

Employee Last Name:	Employee First Name:	Mid. Initial
Email Address:	Cell Phone#:	
Street Address:	Apt. #:	
City:	State:	ZIP code:

Date of Birth:____/___/____

Health Coverage Elected (select one): __ Individual/Employee __ Employee + spouse __ Employee + Child(ren) __ Family

Gender: ___ Male ___ Female

Employee Social Security #:_____—_____— _____

Telephone #: Business: (_____)_____Home: (____)_____ Date of Hire: ____/____/_____

Employment Status: __ Actively at Work __ COBRA __ Retired If retired, retirement date: ___/___/____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ___No __ Yes

If Yes, the section below must be completed:

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

FAMILY COVERAGE INFORMATION: List all eligible dependents.

____Spouse ____Civil Union Partner

__Male __ Female

Last Name (only if different):_____Date of Birth: ___/___/_____

First Name:_____Social Security #:_____—_____— _____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ___No ___Yes
If Yes, the section below must be completed:

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

FAMILY AND DEPENDENT COVERAGE INFORMATION:

List all eligible dependents: *If disabled child is over the dependent age limit of your employer's plan, please attach a completed Dependent Child's Statement of Disability form. If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application.*

____SON _____ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different):_____First Name: _____

___ ELIGIBLE MILITARY PERSONNEL ___ DISABLED DEPENDENT

Address (if different from employee's address): _____

Social Security #:_____—_____—_____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? __No __Yes
If Yes, the section below must be completed:

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

____SON ____ DAUGHTER Date of Birth: ____/____/_____

Last Name (only if different):_____First Name: _____

___ ELIGIBLE MILITARY PERSONNEL __ DISABLED DEPENDENT

Address (if different from employee's address): _____

Social Security #:_____—_____—_____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? __No __Yes
If Yes, the section below must be completed:

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

____SON ____ DAUGHTER Date of Birth: ___/___/____

Last Name (only if different):_____First Name: _____

___ ELIGIBLE MILITARY PERSONNEL ___ DISABLED DEPENDENT

Address (if different from employee's address): _____

Social Security #:_____—_____—_____

Are you covered or applying for coverage under your employer's health care plan, and are you also covered by Medicare? ___No ___Yes
If Yes, the section below must be completed:

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

OTHER INSURANCE INFORMATION:

If you or any of your family members have OTHER GROUP COVERAGE, Check all that apply.

☐Health: Policy #:_____) Dental: Policy #: _____

☐Prescription Drug Coverage: Policy #:_____) Vision: Policy #: _____

☐Hearing: Policy #: _____

If Yes: Is the other insurance: _Single Coverage _Family Coverage

EMPLOYED BY:_____Insured's Name: _____

Date of Birth:___/___/____

Insurance Company Name: _____

Address: _____

City:_____State:_____ZIP code:_____Telephone #: _____

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

Date Signed:____/___/____Signature of Applicant: _____

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

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

Medical for: _Myself _My spouse* _My spouse and dependents __ My dependents _Myself, my spouse and my dependents

Dental for: __ Myself __ My spouse* __ My spouse and dependents __ My dependents __ Myself, my spouse and my dependents

Reason: _Covered under spouse's* employer-based health insurance plan (complete "Other Insurance Information" in Section O)

☐Covered under a Medicare supplement plan

☐Other (please explain)_____

Date Signed: ___/___/___ Signature of Applicant: _____

* The use of the term "spouse" in Section 12 includes a legal spouse, domestic partner or party to a civil union. All of the provisions of this section of the form that pertain to a spouse also apply to a domestic partner or party to a civil union unless specifically noted otherwise.