Welcome to Blue Cross and Blue Shield of Illinois and Fort Dearborn Life

To enroll yourself and your eligible dependents, follow directions on the next page for help in completing the Employee Application on pages 1 and 2.

If your group has *50 or fewer* enrollees, please complete the Medical Questionnaire on page 3 (see number 8 on the directions page for details). Note that your employer may ask you to complete the Medical Questionnaire even if your group has more than 50 enrollees.

If you are declining *any coverage* being offered to you through Blue Cross or Fort Dearborn Life, please complete and sign the Waiver of Coverage form on page 4.

Thank you.

FORT DEARBORN LIFE INSURANCE COMPANY

BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee
of the Blue Cross and Blue Shield Association

Directions for Completing the Employee Application

Please use black pen only. Do not abbreviate. Complete all fields, answering each question as accurately as possible. **If you are unsure or have questions about any of the information requested on this form, please contact your Group Administrator.** Additional forms are required for some policy changes.

1. **Enrollment Information.** Select the reason you are completing this form and check the appropriate box
   - **New Enrollment:**

     Timely Enrollment: This is your first opportunity to enroll after becoming eligible.

     Special Enrollment: You are enrolling within 31 days of a qualifying event such as birth, adoption, or placement for adoption, marriage, divorce or involuntary loss of other coverage. For Fort Dearborn Life coverage, this provision is only applicable to Dependent Life coverage.

     Late Enrollment for Life and Disability plans: Late enrollees must furnish acceptable evidence of insurability if the employer contributes less than 100%. If the employer contributes 100%, such person's effective date will be a date mutually agreed to by the insurance company and the employer.
   - **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current policy - normally 30 days prior to the anniversary date of the program. Under the Voluntary Life plan, employees applying for or increasing coverage after their initial eligibility period can only enroll during the employer's annual enrollment period. Satisfactory evidence of insurability will be required for Voluntary Life coverages in these circumstances.
     For non-Voluntary Life and Disability plans, refer to "Late Enrollment" above. In addition, the following applies to all coverages:

     New Member: You are a newly hired employee who becomes eligible at Open Enrollment or a current employee who elects coverage for the first time.

     Plan Change: You are changing your current coverage.

     Add Dependents: You are adding spouse and/or children to your coverage.

2. **Coverage Applied For.** Provide the information requested in Section 2. Select Employee, Employee + Spouse, Employee + Child(ren), or Family Coverage. Select one of the health plans as offered by your employer. Select one dental and life plan as offered by your employer. If you are enrolling with Fort Dearborn Life, list all beneficiaries that apply, providing both the first and last name, their relationship to you and their age. If additional space is needed, attach a separate piece of paper. If you are declining dental or life coverage for yourself, or if you are declining health coverage for yourself, your spouse or your children, please complete the waiver of coverage form (EB5254) attached to this application. **Your signature is required if you are declining any of the coverages offered.**

3. **If you are or your dependents are covered by Medicare** enter the HIC number, which is the Medicare claim number on the Medicare ID card. *Be sure to enter the start dates where they apply:* Medicare A, Medicare B, End Stage Renal Disease (ESRD) Dialysis, and Disability. The ESRD start date is the day ESRD regular course of dialysis begins (or the date of kidney transplant in the case of total renal failure). The disability start date is the day you or your dependents are entitled to Medicare due to disability.

4. **Employee Coverage Information.** Fill in every section that applies to you.
   If you selected HMO coverage: you must select a Medical Group or IPA (Independent Practice Association) *for each person to be covered.*
   You must also select a PCP (Primary Care Physician*) from within the Medical Group/IPA you choose. You may choose a different Medical Group/IPA for each person. Until we receive this information you are not eligible to receive medical services and your claims will be denied.

   *Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

5. **Family Coverage Information.** Answer every question if you have a spouse or any children applying for coverage.
   Spouse – Enter complete information. If you chose HMO coverage, complete the HMO section as instructed above.
   Children – Enter complete information. If you chose HMO coverage, complete the HMO section as instructed above.
   If necessary use a separate piece of paper and attach it to this application.

6. **Other Insurance Information.** If you, your spouse or any of your children are applying for coverage and have other insurance coverage, enter the requested information **completely**. This information will allow for the proper coordination of your benefits.

7. **Application for Coverage.** Please read, date and sign this section. Your signature is required if you are electing any coverage.

8. **Health Questions.** To be completed and signed by employees of groups of 2-50 enrolled employees or any groups (regardless of size) that elect to be Medically Underwritten. Employees in groups of 2-25 enrolled employees should complete sections 8A and 8B. Employees in groups of 26-50 enrolled employees only need to complete section 8A. For Health coverage, employees of groups of more than 50 enrolled employees need not complete this form. For Fort Dearborn Life Coverage: The health questions (sections 8A and 8B) must be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment. Without a signature here, the application cannot be considered complete and will be returned.

9. **Waiver of Coverage.** If you are declining dental or life coverage, or if you are declining health coverage for yourself, your spouse or your children, please complete the Waiver of Coverage form (EB5254) attached to this application. Your signature is required for any waiver of coverage. If you are not declining any coverage, please do not complete this form.

FORT DEARBORN LIFE INSURANCE COMPANY

Employee Application

BlueCross BlueShield of Illinois
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

1. Enrollment Information:

New Enrollment: ❑ Timely ❑ Special ❑ Late

Open Enrollment: ❑ New Member ❑ Plan Change ❑ Add Dependents

Group and Section Number	Employee Social Security #
	__ __ __ /___ ___/ __ __ __ __

Employer Name	Effective Date	Date of Employment
	___ ___ /___ ___/ ___ ___ ___ ___	___ ___ /___ ___/ ___ ___ ___ ___

Employee Last Name	First Name	MI

Street Address	Apt. #	City	State	Zip Code

Date of Birth	Business Telephone Number	Home Telephone Number	Sex
___ ___ /___ ___/ ___ ___ ___ ___	( )	( )	❑ Male ❑ Female

Previous Blue Cross and Blue Shield of Illinois Group # (if applicable):

Employment Status: ❑ Active Employee ❑ Retired ❑ COBRA/IL ❑ If Retired, Retirement Date: ___/____/____

COBRA/IL Continuation Privilege: Start Date ___/____/____ Projected End Date: ___/____/____

Previously covered with group as:

❑ 1. Employee (Termination of employment, Reduction in hours, other.)
❑ 2. Spouse (Divorce from employee, Death of employee.)
❑ 3. Dependent (Reached age limit, Married, No longer full time student, other.)
❑ 4. Spouse & Dependents (Divorce from employee, Death of employee, other)

2. Coverage Applied for: Check all that apply based on the plans offered by your employer.

Health Plans*

Check one: ❑ Employee ❑ Employee + Spouse
❑ Employee + Child(ren) ❑ Family

Check one: ❑ PPO ❑ CPO

❑ HMO *select your PCP in Section 4*

❑ Alternative Plan (BAE only)

❑ BluePrint PPO Value Choice

BlueCare Dental Options*

If applying for dental, please complete.

Check one: ❑ Employee ❑ Employee + Spouse
❑ Employee + Child(ren) ❑ Family

❑ Dental PPO

❑ Traditional Dental

❑ Dental HMO Dental Group #: _____

**actual billed premiums will be dependent upon the group contract in force.*

Fort Dearborn Life (FDL) If applying for FDL, please complete

FDL Group #: Class:

Job Title:

Basic Salary (exclude bonuses) $

❑ Hourly ❑ Weekly ❑ Semi-Monthly ❑ Monthly ❑ Annual

Number of hours worked in a normal work week:

❑ Term Life / A D & D ❑ Voluntary Life

❑ Dependent Life Employee Amount $ _____

❑ Short Term Disability Spouse Amount $ _____

FDL Beneficiary: If more than one beneficiary is named, interest will be equal unless otherwise indicated.

1. Last Name _____ First Name _____
Relationship _____ Age_____ Percentage _____

2. Last Name _____ First Name _____
Relationship _____ Age_____ Percentage _____

3. Medicare/ESRD Coverage Information If you or your dependents are covered under your employer's health plan and covered by Medicare, please complete.

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

4. Employee Coverage Information - HMO - If selected

If you chose HMO: Medical Group/IPA#	Medical Group/ IPA Name:	Primary Care Physician Name*:
WPHCP Medical Group/IPA#	WPHCP Medical Group/IPA Name:	WPHCP (Physician) Name

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

Employer Name:

Employee Social Security # __ __ __-__ __-__ __ __ __

5. Family Coverage Information: Complete for your spouse and all children to be covered.

Last Name (if different) | First Name | MI

Spouse: Date of Birth ____/____/______ Social Security # __ __ __ - __ __ - __ __ __ __

If you chose HMO: Medical Group/IPA# | Medical Group/ IPA Name: | Primary Care Physician Name*:

WPHCP Medical Group/IPA# | WPHCP Medical Group/IPA Name: | WPHCP (Physician) Name

Last Name (if different) | First Name | MI

❑ **Son:** ❑ **Daughter:** Date of Birth ____/____/______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you chose HMO: Medical Group/IPA# | Medical Group/ IPA Name: | Primary Care Physician Name*:

WPHCP Medical Group/IPA# | WPHCP Medical Group/IPA Name: | WPHCP (Physician) Name

Last Name (if different) | First Name | MI

❑ **Son:** ❑ **Daughter:** Date of Birth ____/____/______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you chose HMO: Medical Group/IPA# | Medical Group/ IPA Name: | Primary Care Physician Name*:

WPHCP Medical Group/IPA# | WPHCP Medical Group/IPA Name: | WPHCP (Physician) Name

Last Name (if different) | First Name | MI

❑ **Son:** ❑ **Daughter:** Date of Birth ____/____/______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you chose HMO: Medical Group/IPA# | Medical Group/ IPA Name: | Primary Care Physician Name*:

WPHCP Medical Group/IPA# | WPHCP Medical Group/IPA Name: | WPHCP (Physician) Name

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

6. Other Insurance Information: Complete ONLY if you have other group coverage.

If you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved, please complete the following section. Check all that apply. This information will be used to coordinate benefits with the other insurance company.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number ______________ ❑ Single ❑ Family

Name of Insured: | SSN: __ __ __ / __ __ /__ __ __ __ | Date of Birth: ___/___/______

Employer Name: | Name and Address of Insurance Company:

City | State | Zip | Telephone #

Dental coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number ______________ ❑ Single ❑ Family

Name of Insured: | SSN: __ __ __ / __ __ /__ __ __ __ | Date of Birth: ___/___/______

Employer Name: | Name and Address of Insurance Company:

City | State | Zip | Telephone #

7. Application for Coverage

I apply for coverage as indicated above, for which I am or may become eligible under the agreement with Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (providing hospital, medical, dental and health maintenance coverage) and/or Fort Dearborn Life Insurance Company (providing life and disability insurance) which are herein collectively called 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.

Authorization

I authorize any medical professional, hospital, other medical facility or medical provider to disclose to the Company underwriting department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the date that you receive notice of the Company's decision on my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws. I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

Signature of Employee to be covered: ______________________________________ Date Signed: __________

FORT DEARBORN LIFE INSURANCE COMPANY

Medical Questionnaire

BlueCross BlueShield of Illinois
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Employee Social Security #
__ __ __-__ __-__ __ __ __

Group Name					
Employee Name	❑ Male ❑ Female	D.O.B__/__/__	Height	Weight	lbs.
Spouse Name	❑ Male ❑ Female	D.O.B__/__/__	Height	Weight	lbs.
Dependent(s)	D.O.B__/__/__	**Dependent**		D.O.B__/__/__	
Dependent(s)	D.O.B__/__/__	**Dependent**		D.O.B__/__/__	

HEALTH QUESTIONS

To be completed and signed by employees of groups of 2-50 enrolled employees electing health coverage and/or for applicable employees of groups electing FDL coverage, or any combination. Employees of groups electing health coverage with more than 50 enrolled employees need not complete this form.

8A. COMPLETE THIS SECTION IF YOUR EMPLOYER HAS 2-50 ENROLLED EMPLOYEES.

For Health Coverage: To be completed and signed by the employee if the group has 2-50 employees enrolled for health coverage.
For Fort Dearborn Life Coverage: To be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment.

1. Have you or any dependent to be covered been hospitalized or had surgery in the past 12 months, or has surgery been advised or recommended? ❑ **Yes** ❑ **No**
2. Are you, your spouse, or any dependent currently pregnant? ❑ **Yes** ❑ **No**
   If yes, date of anticipated delivery: _____
3. In the past five years, have you or any dependents to be covered been diagnosed or treated by a physician or hospitalized for any medical conditions, such as: stroke, cancer, emphysema or respiratory disorder, AIDS or tested positive for HIV, alcohol/drug/substance dependency or abuse, kidney/pancreas disorder, diabetes, inflammatory bowel/gastrointestinal disorder, lupus, multiple sclerosis, seizure disorder, hepatitis, leukemia, blood or liver disease, mental or emotional disorder, cardiovascular or circulatory disorder, infertility? ❑ **Yes** ❑ **No**

If you have answered YES to any of the above questions, please provide details in section 8C below. Attach a separate sheet of paper if more space is needed.

8B. IF YOUR EMPLOYER HAS 2-25 ENROLLED EMPLOYEES, COMPLETE THIS SECTION IN ADDITION TO 8A.

For Health Coverage: To be completed and signed by the employee if the group has 2-25 employees enrolled for health coverage.
For Fort Dearborn Life Coverage: To be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment.

1. Please answer all questions. In the past five years, has any person for whom this application is being made (including yourself, spouse, and any children) been hospitalized, advised, or treated by a physician for:
   - a. Epilepsy, seizure disorder, Parkinson's disease, brain or central nervous system disorder, behavioral disorder, anxiety, depression, or any form of psychological counseling or therapy? ❑ Yes ❑ No
   - b. High blood pressure, heart attack, bypass, or vascular disorder? ❑ Yes ❑ No
   - c. Asthma, apnea, or any lung disorder? ❑ Yes ❑ No
   - d. Colitis, Crohn's disease, ulcer of the stomach or duodenum, rectal disorder, cirrhosis, gall bladder or any digestive disorder? ❑ Yes ❑ No
   - e. Kidney, breast, bladder or any other urinary disorder or disorder of the prostate, genital or reproductive organs? ❑ Yes ❑ No
   - f. Thyroid disorder, gout, any eye, ear, or nose disorder, any discolored areas or lesions of the skin or mouth? ❑ Yes ❑ No
   - g. Arthritis, rheumatism, any disorder of the back, spine, bones, muscles or joints? ❑ Yes ❑ No
   - h. Tumor, growth, enlarged lymph nodes or any skin disorder? ❑ Yes ❑ No
   - i. Infertility, including taking medication or being advised to seek treatment, diagnostic tests or surgery? ❑ Yes ❑ No
2. Other than indicated in Question 1 above, in the last five years have you or any other persons for whom application is being made had any physical impairment, deformity, sickness, operation or injury? ❑ Yes ❑ No
3. Has anyone for whom application is being made (you, your spouse or children):
   - a. Taken any prescribed medication in the past 12 months? ❑ Yes ❑ No
   - b. Smoked cigarettes or used tobacco in any form in the past twelve months? ❑ Yes ❑ No
   - c. Ever been declined, postponed, rated, or limited for Life or Health insurance? ❑ Yes ❑ No
   - d. Had a claim or medical expense of $5,000 or more in the past twelve months? ❑ Yes ❑ No
4. Are you unable to work or are you performing your duties part-time due to illness or injury? ❑ Yes ❑ No

If you have answered YES to any of the above questions, please provide details in section 8C below. Attach a separate sheet of paper if more space is needed.

8C. DETAILS

Question#	Person Affected	Condition/ Diagnosis	Treatment Surgery/ Medication	Treatment Dates From/To	Date of Full Recovery	Name of Physician Hospital / Institution

I authorize any medical professional, hospital, other medical facility or medical provider to disclose to the HCSC and FDL (the Company) underwriting department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the date that you receive notice of the Company's decision on my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws. I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

Signature of Employee / Spouse / Dependent (as required by law) **Date**

FORT DEARBORN LIFE INSURANCE COMPANY

Waiver of Coverage

BlueCross BlueShield of Illinois
A Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

Employee Social Security #
__ __ __ - __ __ - __ __ __ __

9. Please complete this form if you are waiving any coverage. If you are not declining any coverage, please do not complete this form.

Employer Name	Group & Section Number			
Employee Last Name	First Name			M I
Street Address	Apt. #	City	State	Zip Code

If you are declining health or dental coverage for yourself, your spouse or your children because of other coverage, you may in the future be able to enroll yourself, your spouse and/or your children in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or child as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and them, provided you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption. ***I acknowledge that I, along with my spouse and/or children (if any), were provided an opportunity to enroll in my employer's Group Health, Life and Dental Insurance plans.***

I DO NOT WISH TO ENROLL FOR: (check all that apply)

Health Plans

❑ I do not wish to enroll for Health coverage. I hereby elect not to enroll in the Group Health Insurance plan for the reason indicated below and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made available with the Company.

Reason:
❑ Covered under spouse's employer-based health insurance plan (Please complete "Other Insurance Information" section below)
❑ Covered under a Medicare supplement plan
❑ Other (please explain) _____

Your signature is required below for any waiver of coverage.

BlueCare Dental Options

❑ I do not wish to enroll for Dental coverage.

Your signature is required below for any waiver of coverage.

Fort Dearborn Life (FDL)

❑ I do not wish to enroll for Life coverage.
❑ I do not wish to enroll for Short Term Disability coverage.
❑ I do not wish to enroll for Long Term Disability coverage.

Your signature is required below for any waiver of coverage.

If you are waiving any or all coverages offered, please remember to complete the "not enrolling" boxes for the coverage types you are waiving. Your signature is required for any waiver of coverage.

Other Insurance Information: Complete ONLY if you have other group coverage.

If you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved, please complete the following section. Check all that apply.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number _____ ❑ Single ❑ Family

Name of Insured: SSN: __ __ __ / __ __ /__ __ __ __ Date of Birth: ___/___/_____

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

Dental coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number _____ ❑ Single ❑ Family

Name of Insured: SSN: __ __ __ / __ __ /__ __ __ __ Date of Birth: ___/___/_____

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

Signature of Employee: _____ Date: _____