BlueCross BlueShield of Illinois

Sangamon County APPLICATION AND POLICY CHANGE Group Number: P14688

① ENROLLEE:	New Enrollment: ☐ Timely ☐ Special ☐ Late	Open Enrollment: ☐ New Member ☐ Plan Change ☐ Add Dependents	
② EFFECTIVE DATE: ___/___/___	Group Number: P14688	Section Number:	Identification Number:
③ COBRA / Illinois Continuation Section	Employee Status: ☐ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ Retiree, retirement date___/___/___		
☐ COBRA: Start Date ___/___/___ Projected End Date ___/___/___			

Previously covered with group as:

☐ 1. Employee (termination of employment, reduction in hours, other.) ☐ 3. Dependent (reach age limit, married, no longer full-time student, other.)

☐ 2. Spouse (divorce from employee, death of employee, other.) ☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ COVERAGE APPLIED FOR: Check all that apply.**

Sangamon County Health Insurance Plan

Check only one box below

BlueCross BlueShield PPO

☐ Subscriber Only

☐ Sub + Child(ren)

☐ Sub + Sps

☐ Sub + Sps + Child(ren)

☐ Waive Medical Coverage

⑤ CHANGES TO EXISTING MEMBERSHIP: Check all that apply.

After checking coverage applied for or making changes to existing membership, complete Group Number, Section Number, Social Security Number and Name.

CHANGES

Date: / /

☐ Name
☐ Address
☐ Telephone
☐ Reinstate

ADD DEPENDENTS

Date: / /

☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: _____

CANCEL DEPENDENTS

Date: / /

☐ Marriage
☐ Divorce
☐ Age Limit
☐ Other: _____

CANCEL (Check all that apply)

Date: / /

☐ Terminate Coverage
☐ Waive Coverage**
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other: _____

NOTE: Only list dependents to be added or dropped in the Family Coverage Information Section ⑦.

**If not electing coverage, please read, complete and sign Section ⑪.

⑥ EMPLOYEE INFORMATION:

Company Name: Sangamon County

Last Name:	First Name:	Mid. Initial	E-Mail Address:

Street Address:	Apt. No.:	City:	State:	Zip:

Date of Birth: ____/____/____ Are You Eligible for Family Coverage: ☐ No ☐ Yes Health Coverage Elected: ☐ Individual/Employee ☐ Employee & Spouse ☐ Employee & Child(ren) ☐ Family

Gender: ☐ Male ☐ Female

Employee Social Security Number: _____ — _____ — _____ Employee Identification Number (if known): _____

Telephone No.: Bus.: (_____) _____ Home: (_____) _____ Date of Hire: _____/_____/_____

Dept. No.: _____

Employment Status: ☐ Actively at Work ☐ Retired If retired, retirement date: _____ ☐ COBRA/IL Continuation

Are you covered under your employer's health care plan and 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: _____/_____/_____

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦Ⓐ SPOUSE: Date of Birth: ____/____/____ Last Name (Only If Different): _____

First Name: _____ Social Security Number: _____ — _____ — _____

Is this dependent covered under your employer's health care plan and 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: _____/_____/_____

BLUE CROSS BLUE SHIELD of Illinois

EMPLOYEE AND DEPENDENT INFORMATION:	Company Name: Sangamon County	Group #: P14688
Employee Last Name	Employee First Name	Mid. Initial

⑦ FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

⑦ ⑧ ☐ SON ☐ DAUGHTER: Date of Birth: ____/____/____ Last Name (Only If Different): _____ First Name: _____
Social Security Number: _____ — _____ — _____

Is this dependent covered under your employer's health care plan and 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: _____
Social Security Number: _____ — _____ — _____

Is this dependent covered under your employer's health care plan and 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: _____
Social Security Number: _____ — _____ — _____

Is this dependent covered under your employer's health care plan and 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: ____/____/____

⑧ 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: _____ Telephone Number: _____

⑩ 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 Fort Dearborn Life Insurance Company (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: _____

⑪ If you are declining enrollment for yourself or your dependents (including your spouse) 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.

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