



APPLICATION AND POLICY CHANGE

PLEASE PRINT — USE BLACK OR BLUE BALLPOINT PEN ONLY — PRESS HARD.

1 ENROLLEE: New Enrollment: Timely Special Late
2 EFFECTIVE DATE: Group Number: Open Enrollment: New Member Plan Change Add Dependents
3 COBRA / Illinois Continuation Section Employee Status: Active Employee COBRA Continuation IL Continuation Retiree, retirement date

4 COVERAGE APPLIED FOR: Check all that apply. 5 CHANGES TO EXISTING MEMBERSHIP: Check all that apply.
Medical: Traditional, HMO Illinois, Blue Advantage HMO, BlueEdge HSA, PPO, BlueEdge HCA, BlueChoice Select, BlueEdge Select HSA, BlueEdge Direct HCA, BlueDecision PPO, PPO Value Choice, CPO, CPO Value Choice, Vision, Hearing, Medicare Supplement
Dental: Individual / Employee, Employee & Spouse, Employee & Child(ren), Family
Dearborn National Group #:
Previous BC (Illinois) or HMO Membership: Group #: Section #:

6 EMPLOYEE INFORMATION: Company Name: CITY OF BERWYN
Last Name: First Name: Mid. Initial: E-Mail Address: Cell Phone Number
Street Address: Apt. No.: City: State: Zip:
Date of Birth: Are You Eligible for Family Coverage: Health Coverage Elected:
Employee Social Security Number: Employee Identification Number (if known):
Telephone No.: Bus.: Home: Date of Hire:
Dept. No.: Payroll Location: Employee Clock No.:
If HMO: Medical Group/IPA #: Medical Group/IPA Name:
PCP #: PCP Name: WPHCP Medical Group/IPA #:
WPHCP Medical Group Name: WPHCP (Physician) #: WPHCP (Physician) Name:
If CPO/CPO Value Choice: Network # CO: If BlueCare Dental HMO: Office ID#:
Employment Status: Actively at Work Retired If retired, retirement date: COBRA/IL Continuation
A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.
7 (A) SPOUSE/DOMESTIC PARTNER: Date of Birth: Last Name (Only If Different):
First Name: Social Security Number:
If HMO: Medical Group/IPA #: Medical Group/IPA Name: WPHCP Medical Group/IPA #:
PCP #: PCP Name: WPHCP Medical Group Name:
WPHCP (Physician) #: WPHCP (Physician) Name: If BlueCare Dental HMO: Office ID#:
A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.
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 A: MEDICARE B: ESRD DIALYSIS: DISABILITY:
Start Date: End Date: Start Date: End Date: Start Date: End Date: Start Date: End Date:

EMPLOYEE AND DEPENDENT INFORMATION: Company Name: CITY OF BERWYN Group #: P55641

Employee Last Name: _____ Employee First Name: _____ Mid. Initial: _____

7 FAMILY COVERAGE INFORMATION: List All Eligible Dependents.

7 **B** SON DAUGHTER Date of Birth: ___/___/___ Last Name (Only if Different): _____ First Name: _____ ELIGIBLE MILITARY PERSONNEL
Address (if different from Employee's address): _____ Social Security Number: _____ If HMO: Medical Group/IPA #: _____

Medical Group/IPA Name: PCP #: _____ PCP Name: _____ WPHCP Medical Group/IPA #: _____
WPHCP Medical Group Name: _____ WPHCP (Physician) #: _____ WPHCP (Physician) Name*: _____
If BlueCare Dental HMO: Office ID#: _____

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: _____ ELIGIBLE MILITARY PERSONNEL
Address (if different from Employee's address): _____ Social Security Number: _____ If HMO: Medical Group/IPA #: _____

Medical Group/IPA Name: PCP #: _____ PCP Name: _____ WPHCP Medical Group/IPA #: _____
WPHCP Medical Group Name: _____ WPHCP (Physician) #: _____ WPHCP (Physician) Name*: _____
If BlueCare Dental HMO: Office ID#: _____

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: _____ ELIGIBLE MILITARY PERSONNEL
Address (if different from Employee's address): _____ Social Security Number: _____ If HMO: Medical Group/IPA #: _____

Medical Group/IPA Name: PCP #: _____ PCP Name: _____ WPHCP Medical Group/IPA #: _____
WPHCP Medical Group Name: _____ WPHCP (Physician) #: _____ WPHCP (Physician) Name*: _____
If BlueCare Dental HMO: Office ID#: _____

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: _____

9 DEARBORN NATIONAL:

Employee Job Title: _____ Class Type: _____

Basic Salary: \$ _____ Hourly Weekly Semi-Monthly Monthly Annually

Check Coverage Applied For: Term Life/AD&D: No Yes \$ _____ Dependent Life: No Yes \$ _____ Weekly Income: No Yes \$ _____
Supplemental Life: No Yes \$ _____ Long Term Disability: No Yes \$ _____ Voluntary AD&D: \$ _____ Single Family
Permanent Life Insurance: No Yes \$ _____ If Yes: Automatic Premium Loan or Replaces An Existing Policy

BENEFICIARY: Note: If more than one Beneficiary, interest will be equal unless otherwise indicated.
Last Name: _____ First Name: _____ Relationship: _____

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 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: _____

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 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 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 **8**) Covered under a Medicare supplement plan
 Other (please explain) _____
Date Signed: ___/___/___ Signature of Applicant: _____

*A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.