



2017 Individual Plan

New Application or Change in Coverage

HOME OFFICE USE ONLY

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To help us process your application promptly, follow the instructions.

- | | |
|----------|---|
| 1 | Print all answers in blue or black ink . Pencil will not be accepted. |
| 2 | Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line. |
| 3 | If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. |
| 4 | Please do not use correction fluid or tape. |

Please submit your application via mail or fax or by calling an agent of Blue Cross and Blue Shield of Illinois (BCBSIL) at 800-477-2000. Please complete the entire application including the selection of a Billing Method in Section D. Please note: If you are applying during a Special Enrollment Period (SEP), proof of a qualifying event must be included to complete your application. Failure to provide appropriate SEP documentation will delay processing of the application.

If you are working with a BCBSIL agent, please remember to include the name of your agent on the back of this application.

APPLY ONLINE	bcbsil.com (Only available during Open Enrollment)
APPLY BY MAIL	Blue Cross and Blue Shield of Illinois - Attn: Individual Enrollment, P.O. Box 3236, Naperville, IL 60566-7236
APPLY VIA FAX	888-223-1988

If you have any questions, please call your agent or call BCBSIL toll-free at 800-477-2000.

If you are applying for coverage during a Special Enrollment Period or "SEP" (an opportunity to enroll outside of Open Enrollment). You may request coverage if you have experienced one or more of the qualifying life events listed below during the last 60 days (check all that apply). You must provide acceptable proof of a qualifying event with this application. BCBSIL will review this proof to verify your eligibility for a SEP. Failure to provide acceptable proof with this application of a qualifying event will delay or prevent the processing of your application and enrollment in coverage. Please call 800-477-2000 for examples of acceptable proof of these qualifying events.

<input type="checkbox"/> 1. I and/or my dependent(s) lost Minimum Essential Coverage: ¹	DATE OF EVENT
<input type="checkbox"/> Involuntary loss due to reasons other than non-payment of premium or rescission on: <input type="checkbox"/> Due to reaching the maximum age, legal separation, divorce, or death of the policyholder, as of: <input type="checkbox"/> I am no longer eligible for my prior health insurance plan due to termination of employment, reduction in number of hours of employment or loss of employer contribution toward my premiums, or I have exhausted my COBRA benefits as of: <input type="checkbox"/> I am no longer residing or living in my prior health insurance plan's HMO service area as of: <input type="checkbox"/> I have a claim that would meet or exceed a lifetime limit on all benefits as of: <input type="checkbox"/> I have lost coverage because my plan no longer offers benefits to the class of similarly situated individuals as of: <input type="checkbox"/> I have lost coverage through my group HMO because I no longer reside or work in the service area and no other package is available as of:	
<input type="checkbox"/> 2. I gained or became a dependent due to marriage on:	DATE OF EVENT
<input type="checkbox"/> 3. I gained or became a dependent due to birth, adoption, or placement for adoption or foster care on:	DATE OF EVENT
<input type="checkbox"/> 4. An error occurred in my previous health plan enrollment, or I have adequately demonstrated that my previous health plan or issuer substantially violated a material provision of its contract with me, as of:	DATE OF EVENT
<input type="checkbox"/> 5. The Health Insurance Marketplace has determined that I or my dependents am/are newly eligible or ineligible for payments of the advanced premium tax credit, or have a change in cost-sharing eligibility, or misconduct by a non-Marketplace entity as of:	DATE OF EVENT
<input type="checkbox"/> 6. I gained access to new health plan options because of a permanent move on:	DATE OF EVENT
<input type="checkbox"/> 7. My current policy is ending on a non-calendar year date (a date other than December 31st), which is: ¹	DATE OF EVENT
<input type="checkbox"/> 8. Other qualifying event. If you do not see your circumstance listed, please work with your agent or contact our sales center at 800-477-2000.	DATE OF EVENT

¹Can apply 60 days in advance.

Section A: Applicant(s)

Applicant Name: _____

SSN#: _____

PRIMARY APPLICANT

NEW COVERAGE ADD DEPENDENT CHANGE IN COVERAGE CONVERSION

FIRST NAME, MIDDLE INITIAL, LAST NAME		SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		
*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE, EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER _____		
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER _____				
RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP				COUNTY
MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)				
PRIMARY PHONE		CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	SECONDARY PHONE	
			CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	
EMAIL ADDRESS			PREFERRED CONTACT METHOD <input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL	
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)†

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER _____	
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER _____					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)					COUNTY
PRIMARY PHONE		CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	EMAIL ADDRESS		PREFERRED CONTACT METHOD
					<input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:			

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER _____	
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER _____					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)					COUNTY
PRIMARY PHONE		CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	EMAIL ADDRESS		PREFERRED CONTACT METHOD
					<input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:			

* Age 18 and over.

** Services must be provided by Primary Care Physician within the Medical Group selected.

† The designation of spouse shall include domestic partners.

Section A: Applicant(s) (Continued)

Applicant Name: _____

SSN#: _____

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER _____	
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER _____					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)					COUNTY
PRIMARY PHONE		CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	EMAIL ADDRESS		PREFERRED CONTACT METHOD <input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL
MEDICAL GROUP** (FOR HMO ONLY)		MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER _____	
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER _____					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)					COUNTY
PRIMARY PHONE		CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	EMAIL ADDRESS		PREFERRED CONTACT METHOD <input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL
MEDICAL GROUP** (FOR HMO ONLY)		MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

FIRST NAME, MIDDLE INITIAL, LAST NAME		RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE SPECIFY:		*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER _____	
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER _____					
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)					COUNTY
PRIMARY PHONE		CELL <input type="checkbox"/> LANDLINE <input type="checkbox"/>	EMAIL ADDRESS		PREFERRED CONTACT METHOD <input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL
MEDICAL GROUP** (FOR HMO ONLY)		MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) <input type="checkbox"/> Y <input type="checkbox"/> N IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

* Age 18 and over.

** Services must be provided by Primary Care Physician within the Medical Group selected.

† The designation of spouse shall include domestic partners.

IF ANY OF THE TELEPHONE NUMBERS ABOVE ARE CELL PHONES, THEN I AGREE TO THE FOLLOWING TYPES OF CONTACTS:

BCBSIL may call me or any one of my dependents with prerecorded or automated calls related to my health care coverage. Y N

BCBSIL may call me or any one of my dependents with information about new plans and benefits. Y N

IF ANY OF THE TELEPHONE NUMBERS ABOVE ARE FOR RESIDENTIAL (LANDLINE) PHONES, THEN I AGREE TO THE FOLLOWING TYPE OF CONTACT:

BCBSIL may call me or any one of my dependents with information about new plans and benefits. Y N

Section B: Applying for Coverage

Applicant Name: _____

SSN#: _____

NOTE: Effective dates are available on the first of the month only, unless otherwise required by law. Applications must be received by BCBSIL within the defined enrollment period to be accepted.

I acknowledge that I have reviewed the providers that are currently in the network for the plan I choose.

PLAN SELECTION	DEDUCTIBLE
<input type="checkbox"/> Blue Choice Preferred Bronze PPO SM 105	\$5,000
<input type="checkbox"/> Blue Choice Preferred Bronze PPO SM 106	\$6,500
<input type="checkbox"/> Blue Choice Preferred Bronze PPO SM 107 – One \$0 PCP Visit	\$6,750
<input type="checkbox"/> Blue Choice Preferred Bronze PPO SM 108	\$7,000
<input type="checkbox"/> Blue Choice Preferred Silver PPO SM 102	\$3,000
<input type="checkbox"/> Blue Choice Preferred Silver PPO SM 103 – Three \$0 PCP Visits	\$3,250
<input type="checkbox"/> Blue Choice Preferred Silver PPO 109 – Standardized SM	\$3,500

PLAN SELECTION	DEDUCTIBLE
<input type="checkbox"/> Blue Precision Bronze HMO SM 103	\$7,100
<input type="checkbox"/> Blue Precision Silver HMO SM 102	\$2,600
<input type="checkbox"/> Blue Precision Silver HMO SM 106	\$5,500
<input type="checkbox"/> Blue Precision Gold HMO SM 101	\$1,750
<input type="checkbox"/> Blue Precision Platinum HMO SM 104	\$250

PLAN SELECTION	DEDUCTIBLE
<input type="checkbox"/> BlueCare Direct Bronze SM 103	\$7,100
<input type="checkbox"/> BlueCare Direct Silver SM 102	\$2,600
<input type="checkbox"/> BlueCare Direct Silver SM 104	\$5,500
<input type="checkbox"/> BlueCare Direct Gold SM 101	\$1,750
<input type="checkbox"/> Blue FocusCare Bronze SM 104	\$7,100
<input type="checkbox"/> Blue FocusCare Silver SM 102	\$5,500
<input type="checkbox"/> Blue FocusCare Silver SM 103	\$2,600
<input type="checkbox"/> Blue FocusCare Gold SM 101	\$1,750

CONVERSION PLAN	DEDUCTIBLE
<input type="checkbox"/> Blue Precision Gold HMO SM 105	\$2,000

Show your present Blue Cross and Blue Shield coverage numbers.

GROUP NUMBER:

CERTIFICATE NUMBER:

LOCATION OF BLUE CROSS AND BLUE SHIELD PLAN (CITY/STATE)

The plan below covers essential health benefits, but only after out-of-pocket cost sharing reaches the high deductible/out-of-pocket maximum required by law.

Select this plan only if you are under 30 before the plan year begins, or have received a certification that you are exempt from the individual mandate because you do not have an affordable coverage option or because you qualify for a hardship exemption. Please enclose a copy of your certificate of exemption with your application.

<input type="checkbox"/> Blue Choice Preferred Security PPO SM 100	\$7,150
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For HMO Only: **ATTENTION FEMALE MEMBERS:** In selecting your Medical Group, remember that your Medical Group's network may affect your choice of OB/GYN. You have the right to receive services from an OB/GYN without first obtaining a referral from your Medical Group. However, if your Medical Group is part of a limited provider network (LPN), the OB/GYN from who you receive services must belong to the same LPN as your Medical Group. This is another reason to make certain that your Medical Group's network includes the specialists – particularly the OB/GYN – and hospitals that you prefer. You are not required to designate an OB/GYN. You may elect to receive OB/GYN services from your Medical Group.

Section C: Dental Coverage

The Affordable Care Act ("ACA") requires us to be reasonably assured that you and each member on this policy have or are seeking coverage for pediatric dental services that are essential health benefits. The Affordable Care Act requires these benefits even if there is no one on the policy who is eligible for these services.

Carriers can offer this required pediatric dental coverage to you through benefit plans called "Marketplace-certified stand-alone dental plans." These plans are also known as Dental Qualified Health Plans or Dental QHPs.

There are three ways to meet this requirement.

- 1 You can enroll in **BlueCare DentalSM**, our Full Dental QHP, which contains coverage for adults and pediatric dental essential health benefits; or
- 2 You can enroll in **BlueCare Dental 4 KidsSM**, our Limited Dental QHP, which only contains pediatric dental essential health benefits; or
- 3 You can confirm that you have obtained or are seeking coverage for pediatric dental essential health benefits somewhere else.

Please review your options below and select **one**:

If you do not select an option then you and each member on the policy will be enrolled in BlueCare Dental 4 Kids 1B, our Limited Dental QHP, in order to meet ACA's requirement that we provide you coverage with pediatric dental services that are essential health benefits.

BlueCare Dental (For All Applicants)	DEDUCTIBLE
<input type="checkbox"/> 1A	\$50
<input type="checkbox"/> 1B	\$75

BlueCare Dental 4 Kids (For Child[ren] Applicants)	DEDUCTIBLE
<input type="checkbox"/> 1A	\$50
<input type="checkbox"/> 1B	\$75

NOTE: Dental plans include an additional premium. For premium information, please call 800-477-2000, or contact your authorized independent BCBSIL agent.

I/WE ALREADY HAVE THE NECESSARY COVERAGE (I AND EACH APPLICANT LISTED ON THIS APPLICATION, ETC.) HAVE OBTAINED COVERAGE FOR PEDIATRIC DENTAL ESSENTIAL HEALTH BENEFITS THROUGH ANOTHER POLICY.

DATE	SIGNATURE

Section D: Billing Information

Applicant Name: _____

SSN#: _____

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

Please select one of the following options to make arrangements for paying your premium.

BANK DRAFT

Bank Draft includes initial and ongoing payments. Payment will be drafted upon receipt of this application. You must complete the Authorization Agreement on the next page.

1-MONTH BANK DRAFT (12 Payments Per Year)

AUTHORIZATION AGREEMENT

Required for Bank Draft Payments Only

I request and authorize BCBSIL and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer-sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the Financial Institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my Financial Institution I understand that I will need to provide at least 10 days advance notice to BCBSIL by telephone prior to a scheduled withdrawal date.

Please complete the following – print or type information

I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.

Please ensure adequate funds are available at the time of application. BCBSIL is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE <input type="checkbox"/> CHECKING ACCOUNT <input type="checkbox"/> SAVINGS ACCOUNT		NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT
BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER	
<input type="checkbox"/> I HAVE READ AND ACCEPT THE ABOVE AGREEMENT		
DEPOSITOR'S SIGNATURE	DATE	RELATIONSHIP TO APPLICANT

DIRECT BILLING

FIRST MONTH PREMIUM AMOUNT OF \$ _____ ENCLOSED

SEND ME A PAPER BILL

1-MONTH DIRECT BILL (12 Payments Per Year)

NOTE: Cashing of the Premium Deposit does not constitute approval of this Application. If this Application is not approved, the Premium Deposit will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

Policy on third-party payments. BCBSIL only accepts premium and cost-sharing payments from: (1) the Applicant; (2) the Applicant's family; (3) Required Entities (the entities the law requires BCBSIL to accept premium and cost-sharing payments from, which currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make premium or cost-sharing assistance available to the Applicant: (a) for the entire coverage period of the Applicant's Contract, (b) regardless of the Applicant's health status, and (c) cannot condition assistance on enrollment with a particular issuer or in a particular benefit plan. BCBSIL does not accept premium and cost-sharing payments from any other third party. A violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to the Applicant's account or coverage, which may result in the termination or cancellation of coverage.

Section E: Proxy Statement

Applicant Name: _____

SSN#: _____

PROXY STATEMENT

PROXY STATEMENT

The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held 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 pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members or by attending and voting in person at any annual or special meeting of members.

PRIMARY APPLICANT'S PROXY SIGNATURE (OPTIONAL):
YOU MUST ALSO SIGN IN "SECTION G" BELOW.

DATE

PRINT YOUR NAME AS YOU SIGNED IT:

Section F: Other Coverage Information

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE, OR DID THEY PREVIOUSLY HAVE **WITHIN THE LAST 5 YEARS**, BCBSIL COVERAGE, OR HEALTH OR MAJOR MEDICAL INSURANCE COVERAGE WITH ANY OTHER INSURER, OR COVERAGE UNDER A TAX SUPPORTED OR GOVERNMENT PROGRAM, INCLUDING MEDICARE, TO THE EXTENT PERMITTED BY LAW, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT? Y N

IF "YES," PLEASE COMPLETE THE FOLLOWING:

APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)

REPLACEMENT OF COVERAGE

WILL THIS INSURANCE REPLACE ANY HEALTH INSURANCE CURRENTLY IN FORCE? Y N

IF "YES," READ THE STATEMENT BELOW AND COMPLETE THE FOLLOWING:

LIST ALL COVERAGE THAT WILL BE REPLACED

INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by BCBSIL. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning any person applying for coverage. Failure to include all material information on any application may provide a basis for BCBSIL to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you not terminate your present contract until you are certain that your application for the new contract has been accepted by BCBSIL.

Section G: Required Signatures

Applicant Name: _____

SSN#: _____

ACKNOWLEDGMENTS

The Applicant, to the best of his/her knowledge and belief, represents and agrees as follows:

1. This application is the first step in applying for Medical Expense Coverage. You do not have Medical Expense Coverage until the effective date of the policy and the first month's premium is paid.
2. If you use an agent or broker, they cannot accept risks or modify policies or requirements of BCBSIL.
3. If a spouse and/or dependent(s) is/are included for medical expense coverage, the premium will be calculated based on the age of each individual covered, subject to applicable law and regulations.
4. I understand that if any person knowingly presents fraudulent claim for payment of a loss or benefit or fraudulently or intentionally misrepresents a material fact on the application, this may result in the coverage being rescinded. Rescission is defined as a cancellation or discontinuance of coverage that has a retroactive effect. I will be provided with at least 30 days advance written notice before my or my dependent's coverage may be rescinded, retroactive to the effective date of coverage.
5. If an Agent, Producer or Broker was working with me to purchase an Individual Policy, then BCBSIL may pay the broker a commission and/or other compensation. I understand that if I want additional information about any commissions or other compensation paid the agent or broker I should contact the agent or broker.

Agreement: I understand that any statements and answers on this application are representations. To the best of my knowledge and belief they are true and complete. These representations are the basis of my application. I understand that coverage will be effective following payment in full of the first month's premium. The undersigned Applicant and broker acknowledge that the Applicant has read the completed application which will become a part of the contract between BCBSIL and the applicant.

Authorization: I authorize any medical professional, hospital, clinic or other medical or medically related facility, governmental agency, pharmacy benefit manager, retail pharmacy, pharmacy clearinghouse or other person or firm, to disclose to BCBSIL or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including and without limitation, information relating to the prescription and use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize BCBSIL to review and research its own records for information. I understand that BCBSIL will only disclose collected information as needed to medical entities related to my care.

I understand information obtained with my authorization may be re-disclosed by BCBSIL as permitted or required by law. If such a disclosure is required, the person or agency receiving the information will become responsible for its protection.

This Authorization is valid for two years from today, or until I terminate coverage. I understand that I have the right to revoke the Authorization at any time, in writing, by contacting BCBSIL. I further understand that I or any authorized representative will receive a copy of this authorization upon request.

Any revocation will not affect the activities of BCBSIL prior to the date such revocation is received by BCBSIL.

Signatures: I acknowledge receipt of the required Outline of Coverage and I agree that Individual Insurance is intended to be paid as my personal expense and that this policy is offered on my representation that only I, a family member, or permissible third party as outlined below will pay BCBSIL directly. I understand that BCBSIL does not accept payments of premiums or cost-sharing payments directly from third parties except from those identified in Section D (family members, Required Entities, certain private non-profit foundations). I understand that a violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to my account or coverage or being refunded to me, which may result in the retroactive termination or cancellation of my coverage.

Special Enrollment Period Attestation and Acknowledgment. I understand that if I am applying for coverage outside of Open Enrollment, I must qualify for a Special Enrollment Period ("SEP"). I understand that in order to qualify for a SEP I must have experienced one of the qualifying events identified on page 1 of the application during the last 60 days, and I must provide acceptable proof of any qualifying event(s) with this application in order for BCBSIL to verify my eligibility.

I represent that the proof I am providing is valid and I understand that failure to provide proof of a qualifying event will delay or prevent the processing of my application and enrollment in coverage.

In addition I acknowledge that this coverage is intended to be individual coverage and nothing in this document creates a group health plan as defined under state and federal laws.

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 is guilty of a felony.

PRIMARY APPLICANT'S SIGNATURE	DATE
SPOUSE'S SIGNATURE (IF APPLYING)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
PARENT OR LEGAL GUARDIAN OF A MINOR CHILD	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:

Section H: Agent Information

Applicant Name: _____

SSN#: _____

AGENT'S CERTIFICATION

Agent's Certification: I certify that I sent the application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the required Outline of Coverage, and if requested, the Disclosure Statement.

AGENT INFORMATION (if applicable)

AGENT'S SIGNATURE	DATE	AGENT ID	P&C CROSS REFERENCE
PRINT AGENT'S NAME	AGENT'S PHONE		AGENT'S FAX

THANK YOU FOR APPLYING.

Please include all necessary materials when submitting this application.

If legal guardian, please enclose signed court decree.