BLUE CROSS BLUE SHIELD ENROLLMENT AND POLICY CHANGE FORM

INSURANCE COSTS JANUARY 01, 2025 THROUGH DECEMBER 31, 2025

SINGLE COVERAGE *(EMPLOYEE ONLY)*

PROVIDES THE EMPLOYEE WITH MEDICAL/DENTAL/VISION/LIFE INSURANCE

$44.28 PER MONTH

$20.44 PER PAY FOR EMPLOYEES ON 26 PAYS
$26.57 PER PAY FOR EMPLOYEES ON 20 PAYS

FAMILY COVERAGE *(EMPLOYEE +1 OR MORE)*

PROVIDES THE EMPLOYEE WITH ALL THE SINGLE COVERGE BENEFITS AND MEDICAL COVERAGE FOR FAMILY

$135.80 PER MONTH

$62.68 PER PAY FOR EMPLOYEES ON 26 PAYS
$81.48 PER PAY FOR EMPLOYEES ON 20 PAYS

FAMILY DENTAL *(EMPLOYEE+1 OR MORE)*

PROVIDES THE EMPLOYEE WITH ALL THE SINGLE COVERGE BENEFITS AND DENTAL COVERAGE FOR FAMILY

$71.06 PER MONTH

$32.80 PER PAY FOR EMPLOYEES ON 26 PAYS
$42.64 PER PAY FOR EMPLOYEES ON 20 PAYS

YOU MUST HAVE FAMILY MEDICAL IN ORDER TO ADD FAMILY DENTAL
~VISION & LIFE INSURANCE ARE EMPLOYEE ONLY BENEFITS~

IMPORTANT PLEASE READ ALL THE WAY TO THE END:

OPEN ENROLLMENT:

OCURRS ANNUALLY, OCTBER 1st - NOVEMBER 30th FOR CHANGES TO BECOME EFFECTIVE JANUARY 1st
THIS IS THE ONLY OPPORTUNITY TO MAKE CHANGES TO YOUR PLAN UNLESS YOU EXPERIENCE A QUALIFYING EVENT MID YEAR

PLEASE USE CHECKLIST BELOW WHEN ENROLLING/MAKING CHANGES:

TO ENROLL IN SINGLE COVERAGE:

_____ Complete All 4 Pages Of The BCBS Enrollment Form, No Other Documentation Is Needed

TO ENROLL IN FAMILY COVERAGE:

ADDING A SPOUSE TO THE PLAN:

To verify the eligibility of your legal spouse, we require both :

_____ A Copy of Your Legal/Certified Marriage Certificate &
_____ A Copy of Your Joint Most Recent Federal Tax Return (first 2 pages, must be signed)

ADDING A BIOLOGICAL CHILD TO THE PLAN (AGE 26 & UNDER):

To verify the eligibility of a biological child, we require one of the followingt:

_____ A Copy of the Certified Birth Certificate or
_____ A Copy of Birth Documentation On Hospital Letterhead *

*Only for children 6 months or younger, must indicate the birth information of the child, as well as the parents' names.

ADDING AN ADOPTED CHILD TO THE PLAN (AGE 26 & UNDER):

To verify the eligibility of an adopted child or a child placed with you for adoption, we require one of the following:
The documents you submit will depend on the current stage of the adoption.

_____ A Copy of the Official Court/Agency Placement Papers For A Child Placed With You (initial)
_____ A Copy of the Official Court Adoption Agreement for Adopted Child (mid)
_____ A Copy of the Certified Birth Certificate (final)

ADDING A STEPCHILD TO THE PLAN (AGE 26 & UNDER):

To verify the eligibility of your stepchild, we require all 3 of the following:
All 3 items must list the child's parent as the employee's spouse

_____ A Copy of the Certified Birth Certificate
_____ A Copy of Your Legal/Certified Marriage Certificate
_____ A Copy of Your Joint Most Recent Federal Tax Return (first 2 pages, must be signed)

IN THE EVENT OF GUARDIANSHIP OF A CHILD (AGE 26 & UNDER):

To verify the eligibility of a child for whom you are the LEGAL GUARDIAN, we require the following:
Including the person or persons named as the legal guardian.

_____ A Copy of the Court Documents Signed & Dated By The Judge Demonstrating Legal Guardianship

IN THE EVENT OF COURT ORDERED MEDICAL COVERAGE OF A CHILD (AGE 26 & UNDER):

If you do not have custody of a child, but you do have a written court order that requires you to provide medical coverage for said child, we require one of the following:

_____ A Copy of the Qualified Medical Child Support Order (QMCSO) or
_____ A Copy of the National Medical Support Notice (NMSN) or
_____ A Copy of Your Divorce Decree

CONTINUING COVERAGE FOR A DISABLED ADULT DEPENDENT:

To verify the continuing eligibility of your disabled child over the age of 26, we require one of the following:

_____ A Copy of the Physician's Current Determination Letter or
_____ A Copy of the Social Security Disability Determination Letter
Letters must be dated within the past 18 months.

TO DROP COVERAGE:

Coverage can only be dropped during open enrollment or if you experience a mid year qualifying event (listed above)

FOR SINGLE COVERAGE:

_____ Submit All 4 pages of the Completed BCBS Enrollment Form

FOR EX SPOUSE:

_____ Submit All 4 pages of the Completed BCBS Enrollment Form &
_____ A Copy of Your Divorce Decree

FOR DEPENDENT CHILD:

_____ Submit All 4 pages of the Completed BCBS Enrollment Form &
_____ A Copy of the Certificate Of Creditable Coverage From The Current Insurance Provider

PLEASE MAKE SURE TO:

_____ Complete the BCBS Enrollment Form, All 4 Pages Need To Be Submitted
_____ Include Required Documentation Listed Above

~Failure to submit all 4 pages of the enrollment form or required documentation for dependents will result in enrollment delays~

THE ENROLLMENT FORM & ALL REQUIRED DOCUMENTATION SHOULD BE SUBMITTED VIA:

_____ Emailed to benefits@joliet86.org or inter office mail to Benefits@JFK/BUS

QUESTIONS?

All benefit related questions should be emailed to ***benefits@joliet86.org***

PLEASE MAKE SURE TO LOOK AT ALL HIGHLGHTED AREAS OF THE ENROLLMENT FORM (4 PAGES) AND COMPLETE ONLY THOSE AREAS THAT PERTAIN TO YOU

BlueCross BlueShield of Illinois

Dearborn National®

APPLICATION AND POLICY CHANGE

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

① **ENROLLEE:**	New Enrollment: ☐ Timely ☐ Special ☐ Late	Open Enrollment: ☐ New Member ☐ Plan Change ☐ Add Dependents	
② **EFFECTIVE DATE OF BENEFITS:** ___/___/___	Group Number: P41595	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 ___/___/___	☐ 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, other.)
☐ 3. Dependent (reach age limit, other.)
☐ 4. Spouse and Dependents (divorce from employee, death of employee, other.)

④ **COVERAGE APPLIED FOR: 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.

Medical

☐ Traditional
☐ HMO Illinois
  ☐ w/HCA (BlueEdge HMO)
☐ BlueAdvantage HMO
  ☐ w/HCA (BlueEdge HMO)
☐ BlueEdge HSA

☑ PPO THIS IS THE ONLY OPTION
☐ BlueEdge HCA
☐ Blue*Choice* Select
☐ BlueEdge Select HSA
☐ BlueEdge Select HCA
☐ BlueEdge Direct HCA
☐ BlueEdge Select Direct HCA
☐ Blue Choice Options

☐ BlueDecision PPO
☐ PPO Value Choice
☐ CPO
☐ CPO Value Choice
☐ Vision
☐ Hearing
☐ Medicare Supplement

Dental

☐ Individual / Employee ☐ Employee & Spouse
☐ Employee & Child(ren) ☐ Family

Enter Dental Group number if different than Medical Group policy number.

☐ Dental Group #: _____

☑ BlueCare Dental PPO THIS IS THE ONLY OPTION

☐ BlueCare Dental HMO (Select your dental office in section 6 and 7 when applicable)

LIFE INS INCLUDED WITH BENEFIT PACKAGE FOR EMPLOYEE ONLY

Dearborn National Group #: F011290-0001

Previous BC (Illinois) or HMO Membership:

Group #: _____ Section #: _____

Identification #: _____

⑤ **CHANGES TO EXISTING MEMBERSHIP: Check all that apply.**

CHANGES
Date ___/___/___
☐ HMO Medical Group/IPA
☐ PCP and/or WPHCP
☐ Name
☐ Address
☐ Telephone
☐ Reinstate
☐ From PPO to HMO
☐ From HMO to PPO
☐ From HMOI to BA HMO
☐ From BA HMO to HMOI
☐ Medicare Coverage
☐ FDL Beneficiary

ADD DEPENDENTS
Date 1 / 1 / 25
☐ Marriage
☐ Newborn
☐ Adoption/Placement
☐ Legal Guardianship
☐ Other: OPEN ENROLLMENT

CANCEL DEPENDENTS
Date 12 /31 / 24
☐ Divorce
☐ Age Limit
☐ Other: OPEN ENROLLMENT

CANCEL (Check all that apply)
Date 12 / 31 / 24
☐ Terminate Coverage
☐ Waive Coverage**
☐ Leave/Layoff
☐ Out of Service Area Move
☐ Other: OPEN ENROLLMENT

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

*After checking the appropriate physician change, circle reason:
☐ PCP
☐ WPHCP

A. Availability
C. Location
E. Dissatisfied with PCP
G. Staff

B. PCP moved office
D. PCP added to Network
F. PCP office/facility undesirable
H. Other _____

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

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⑥ **EMPLOYEE INFORMATION:**	Company Name:	
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: ☐ 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.: _____ 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.

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 ☐ Domestic Partner ☐ Party to a Civil Union ☐ Male ☐ Female 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 B:	ESRD DIALYSIS:	DISABILITY:
MEDICARE A:	Start Date: ___/___/___	Start Date: ___/___/___	Start Date: ___/___/___
Start Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___	End Date: ___/___/___

⑥ **EMPLOYEE AND DEPENDENT INFORMATION:**	Company Name:	Group #:
Employee Last Name:	Employee First Name:	Mid. Initial
⑦ **FAMILY COVERAGE INFORMATION:**	List All Eligible Dependents.	

⑦Ⓑ ☐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 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 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.