BlueCross BlueShield of Illinois

O'Fallon CCSD#90
P40148 (PPO) P76927 (H.S.A.)

Dearborn National®

APPLICATION AND POLICY CHANGE

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: ***P40148 (PPO)*** ***P76927 (H.S.A.)***	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 - Please check one

☐ Option 1 - HRA Plan P40148 ☐ Option 2 - High Deductible Plan P40148 ☐ Option 3 - H.S.A. Plan P76927

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

CHANGES	ADD DEPENDENTS	CANCEL DEPENDENTS	CANCEL (Check all that apply)
Date ___/___/___	Date ___/___/___	Date ___/___/___	Date ___/___/___
☐ Name	☐ Marriage	☐ Divorce	☐ Terminate Coverage
☐ Address	☐ Newborn	☐ Age Limit	☐ Waive Coverage**
☐ Telephone	☐ Adoption/Placement	☐ Other:	☐ Leave/Layoff
☐ Reinstate	☐ Legal Guardianship	_____	☐ Out of Service Area Move
☐ From PPO to HSA	☐ Other: _____		☐ Other: _____

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: *O'Fallon CCSD #90*	
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.: _____

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 ☐ Domestic Partner ☐ Party to a Civil Union ☐ Male ☐ Female 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: ___/___/___

⑥ **EMPLOYEE AND DEPENDENT INFORMATION:**	Company Name: *O'Fallon CCSD #90*	Group #: *P40148 / P76927*
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: ______ — ______ — __________

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: ______ — ______ — __________

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: ______ — ______ — __________

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 #: _____

☐ Prescription Drug Coverage: 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 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: _____

O'Fallon CCSD#90
Benefits Election Form – Medical Enrollment 2016
Effective January 1, 2018

Please make your coverage selections below, and sign and return this form to Carrie Bowen

If you do not wish to participate in a plan, please check the box marked "waive," sign and return the form.

Employee Name (please print)

I choose the following medical insurance coverage:

Medical Insurance 26 pays	***Medical Insurance 20 pays***
Plan Option 1 –HRA Plan *(26 pays)*	**Plan Option 1 –HRA Plan *(20 pays)***
☐ Employee only - $4.21	☐ Employee only - $5.48
☐ Employee & Spouse - $231.42	☐ Employee & Spouse - $300.85
☐ Employee & Child(ren) - $210.04	☐ Employee & Child(ren) - $273.05
☐ Family - $245.80	☐ Family - $319.54
Plan Option 2 – *(26 pays)* **High Deductible Plan – NO HRA**	**Plan Option 2 – *(20 pays)*** **High Deductible Plan – NO HRA**
☐ Employee only - $0.00	☐ Employee only - $0.00
☐ Employee & Spouse - $181.38	☐ Employee & Spouse - $235.80
☐ Employee & Child(ren) -$161.70	☐ Employee & Child(ren) - $210.22
☐ Family - $191.87	☐ Family - $249.43
Plan Option 3 – H.S.A *(26 pays)*	**Plan Option 3 – H.S.A *(20 pays)***
☐ Employee only - $0.00	☐ Employee only - $0.00
☐ Employee & Spouse - $68.42	☐ Employee & Spouse - $88.94
☐ Employee & Child(ren) - $52.58	☐ Employee & Child(ren) - $68.36
☐ Family - $70.13	☐ Family - $91.17

☐ **Waive – NO COVERAGE**

I acknowledge I was offered an employer sponsored group health plan that meets the Affordable Care Act's affordability and minimum value requirements but I choose not to participate in the medical plan.

IMPORTANT→ If you are a new enrollment or adding dependents you will need to complete a BCBS change form in addition to this election form to provide your personal enrollment information. Please contact Cornerstone Insurance Group.

I understand the coverage I have elected is effective January 1, 2018.

Signature | Date