FORT DEARBORN LIFE INSURANCE COMPANY

BlueCross BlueShield of Illinois

Welcome to Blue Cross and Blue Shield of Illinois and Fort Dearborn Life

To enroll yourself and your eligible dependents, follow directions on the next page for help in completing the Employee Application on pages 1 and 2.

If your group has *50 or fewer* enrollees, please complete the Medical Questionnaire on page 3 (see the directions page for details). Note that your employer may ask you to complete the Medical Questionnaire even if your group has more than 50 enrollees.

If you are declining *any coverage* being offered to you through Blue Cross or Fort Dearborn Life, please complete and sign the Waiver of Coverage form on page 4.

Thank you.

Directions for Completing the Employee Application

Please use black or blue pen only. Do not abbreviate. Complete all fields, answering each question as accurately as possible. **If you are unsure or have questions about any of the information requested on this form, please contact your Group Administrator.**

1. **Enrollment Information.** Select the reason you are completing this form and check the appropriate box

   • **New Enrollment:**

   Timely Enrollment: This is your first opportunity to enroll after becoming eligible.

   Special Enrollment: You are enrolling within 31 days of a special enrollment event as specified in the federal HIPAA regulations (e.g. birth, adoption, or placement for adoption, marriage, divorce or involuntary loss of other coverage). For Fort Dearborn Life coverage, this provision is only applicable to Dependent Life coverage.

   Late Enrollment for Life and Disability plans: Late enrollees must furnish acceptable evidence of insurability if the employer contributes less than 100%. If the employer contributes 100%, such person's effective date will be a date mutually agreed to by the insurance company and the employer.

   • **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current policy - normally 30 days prior to the anniversary date of the program. Under the Voluntary Life plan, employees applying for or increasing coverage after their initial eligibility period can only enroll during the employer's annual enrollment period. Satisfactory evidence of insurability will be required for Voluntary Life coverages in these circumstances.
   For non-Voluntary Life and Disability plans, refer to "Late Enrollment" above. In addition, the following applies to all coverages:

   New Member: You are a newly hired employee who becomes eligible at Open Enrollment or a current employee who elects coverage for the first time.

   Plan Change: You are changing your current coverage.

   Add Dependents: You are adding spouse and/or children to your coverage.

   If known, enter your Group, Section and Identification numbers and effective date. Enter your social security number and date of employment.
   • If this is your initial enrollment, you do not need to enter your Identification number.
   • Your Social Security number is used for internal purposes only.

2. **Coverage Applied For.** Provide the information requested in Section 2. Select Employee, Employee + Spouse, Employee + Child(ren), or Family Coverage. Select one of the health plans as offered by your employer. Select one dental and life plan as offered by your employer. If you are enrolling with Fort Dearborn Life, list all beneficiaries that apply, providing both the first and last name, their relationship to you and their age. If additional space is needed, attach a separate piece of paper. If you are declining dental or life coverage for yourself, or if you are declining health coverage for yourself, your spouse or your children, please complete the Waiver of Coverage form attached to this application. **Your signature is required if you are declining any of the coverages offered.**

3. **If you are or your dependents are covered by Medicare** enter the HIC number, which is the Medicare claim number on the Medicare ID card. *Be sure to enter the start dates where they apply:* Medicare A, Medicare B, End Stage Renal Disease (ESRD) Dialysis, and Disability. The ESRD start date is the day ESRD regular course of dialysis begins (or the date of kidney transplant in the case of total renal failure). The disability start date is the day you or your dependents are entitled to Medicare due to disability.

4. **Employee Coverage Information.** Fill in every section that applies to you.
   If you selected HMO coverage: you must select a Medical Group or IPA (Independent Practice Association) and a Primary Care Physician (PCP)* *for each person to be covered.* The PCP selected must be from within your Medical Group/IPA. You may choose a different Medical Group/IPA for each person. Until we receive this information you are not eligible to receive medical services and your claims will be denied. Be sure to enter the Medical Group/IPA number, name, PCP number and name.

   *Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

   If you selected CPO or CPO Value Choice coverage: you must select a CPO Network.
   If you selected Dental HMO: include your Dental HMO group number and select a Dental HMO office for each person to be covered.

5. **Family Coverage Information.** Answer every question if you have a spouse or any children applying for coverage.
   Spouse – Enter complete information. If you chose HMO coverage, complete the HMO section as instructed above.
   Children – Enter complete information. If you chose HMO coverage, complete the HMO section as instructed above.
   If necessary use a separate piece of paper and attach it to this application.

6. **Other Insurance Information.** If you, your spouse or any of your children are applying for coverage and have other insurance coverage, enter the requested information **completely**. This information will allow for the proper coordination of your benefits.

7. **Application for Coverage.** Please read, date and sign this section. Your signature is required if you are electing any coverage.

Health Questions. To be completed and signed by employees of groups of 2-50 enrolled employees or any groups (regardless of size) that elect to be Medically Underwritten. For Health coverage, employees of groups of more than 50 enrolled employees need not complete this form. For Fort Dearborn Life Coverage: The health questions must be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment. Without a signature here, the application cannot be considered complete and will be returned. Signature of spouse is required if spouse is applying for coverage.

Waiver of Coverage. If you are declining dental or life coverage, or if you are declining health coverage for yourself, your spouse or your children, please complete the Waiver of Coverage form attached to this application. Your signature is required for any waiver of coverage. If you are not declining any coverage, please do not complete this form.

FORT DEARBORN LIFE INSURANCE COMPANY

Employee Application

BlueCross BlueShield of Illinois

1. Enrollment Information: Employee Identification # (if known): _____
If this is your initial enrollment, leave blank

New Enrollment: ❑ Timely ❑ Special (If special, reason_____) ❑ Late
(e.g., marriage)

Open Enrollment: ❑ New Member ❑ Plan Change ❑ Add Dependents

Group and Section Number	Employee Social Security #
	__ __ __ /___ ___/ __ __ __ __
Effective Date	**Date of Employment**
___ ___ /___ ___/ ___ ___ ___ ___	___ ___ /___ ___/ ___ ___ ___ ___

Employer Name			
Employee Last Name	First Name	MI	E-Mail Address
Home Mailing Address - Street	Apt. #	City	State / Zip Code
Date of Birth ___ ___ /___ ___/ ___ ___ ___ ___	Business Telephone Number ( )	Home Telephone Number ( )	Gender ❑ Male ❑ Female

Previous Blue Cross and Blue Shield of Illinois Group # (if applicable):

Employment Status: ❑ Active Employee ❑ COBRA Continuation ❑ IL Continuation ❑ If Retiree, Retirement Date: ___/___/___

COBRA / Illinois Continuation Section

❑ 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 (Reached age limit, Married, No longer full-time student, other)
❑ 4. Spouse & Dependents (Divorce from employee, Death of employee, other)

2. Coverage Applied for: Check all that apply based on the plans offered by your employer.

Health Plans*

Check one: ❑ Employee ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family

Check one:

❑ PPO ❑ PPO Value Choice ❑ Blue*Choice* Select
❑ HMO *select your PCP in section 4 and in section 5 when applicable.*
❑ BlueEdge HSA ❑ *integrated with BCBSIL vendor* ❑ *non-integrated*
❑ BlueEdge HCA
❑ BlueEdge Select HSA ❑ *integrated with BCBSIL vendor* ❑ *non-integrated*
❑ BlueEdge Select HCA
❑ CPO ❑ CPO Value Choice ❑ BlueDecision PPO

BlueCare Dental Options*

If applying for dental, please complete.

Check one: ❑ Employee ❑ Employee + Spouse ❑ Employee + Child(ren) ❑ Family

Check one: ❑ Dental PPO ❑ Dental HMO
select your dental office in section 4 and 5 when applicable
Dental HMO Group #:_____

**actual billed premiums will be dependent upon the group contract in force.*

Fort Dearborn Life (FDL) If applying for life coverage, please complete.

FDL Group #: Class:

Job Title:

Basic Salary (exclude bonuses) $

❑ Hourly ❑ Weekly ❑ Semi-Monthly ❑ Monthly ❑ Annual

Number of hours worked in a normal work week:

❑ Term Life / A D & D ❑ Voluntary Life
❑ Dependent Life Employee Amount $ _____
❑ Short Term Disability Spouse Amount $ _____

FDL Beneficiary: If more than one beneficiary is named, interest will be equal unless otherwise indicated.

1. Last Name _____ First Name_____
Relationship _____ Age_____ Percentage _____
2. Last Name _____ First Name_____
Relationship _____ Age_____ Percentage _____

3. Medicare/ESRD Coverage Information If you or your dependents are covered under your employer's health plan and covered by Medicare, please complete.

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

4. Employee Coverage Information — HMO — CPO — DENTAL HMO — If selected

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

If you have chosen CPO/CPO Value Choice: Network # CO_____**Dental HMO Office ID #**_____

Employer Name:

Employee Social Security #
__ __ __-__ __-__ __ __ __

5. Family Coverage Information: Complete for your spouse and all children to be covered.

Last Name (if different) First Name MI

Spouse: Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

Last Name (if different) First Name MI

❑ **Son** ❑ **Daughter** Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

Last Name (if different) First Name MI

❑ **Son** ❑ **Daughter** Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

Last Name (if different) First Name MI

❑ **Son** ❑ **Daughter** Date of Birth ____/____/_______ Social Security # __ __ __ - __ __ - __ __ __ __ Full time student? ❑ Yes ❑ No

If you have chosen HMO: Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __Medical Group/IPA Name: PCP # __ __ __ __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ __ __ __ __ __ __ __ __WPHCP Medical Group/IPA Name: WPHCP# __ __ __ __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

Dental HMO Office ID#______________________________

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

6. Other Insurance Information: Complete ONLY if you or your dependents have other group coverage.

Do you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved? ❑ Yes ❑ No

If yes, complete the following section. Check all that apply. This information will be used to coordinate benefits with the other insurance company.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number _______________ ❑ Single ❑ Family

Name of Insured: SSN: __ __ __ / __ __ /__ __ __ __ Date of Birth: ___/___/_______

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

Dental coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other Policy Number _______________ ❑ Single ❑ Family

Name of Insured: SSN: __ __ __ / __ __ /__ __ __ __ Date of Birth: ___/___/_______

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

7. Application for Coverage

I apply for coverage as indicated above, for which I am or may become eligible under the agreement with Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (providing hospital, medical, dental and health maintenance coverage) and/or Fort Dearborn Life Insurance Company (providing life and disability insurance) which are herein collectively called 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.

Authorization

I authorize any medical professional, hospital, other medical facility or medical provider to disclose to the Company Underwriting Department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the date that you receive notice of the Company's decision on my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws. I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

Signature of Employee to be covered: ____ Date Signed:____________

FORT DEARBORN LIFE INSURANCE COMPANY

Medical Questionnaire

BlueCross BlueShield of Illinois

Employee Social Security #
__ __ __-__ __-__ __ __ __

Group Name	Group and Section Number		Employee ID #		
Employee Name	■ Male ■ Female	D.O.B____/____/____	**Height**	**Weight**	lbs.
Spouse Name	■ Male ■ Female	D.O.B____/____/____	**Height**	**Weight**	lbs.
Dependent	■ Male ■ Female	D.O.B____/____/____			
Dependent	■ Male ■ Female	D.O.B____/____/____			
Dependent	■ Male ■ Female	D.O.B____/____/____			
Dependent	■ Male ■ Female	D.O.B____/____/____			

HEALTH QUESTIONS

For Health Coverage: To be completed and signed by the employee if the group has 2-50 employees enrolled for health coverage. Signature of spouse is required if spouse is applying for coverage. For Fort Dearborn Life Coverage: To be completed by the employee if the group has two or more eligible employees and is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment.

Directions: Please check ☑ Yes or ☑ No. If any boxes are checked "Yes" (☑ Yes), circle the condition, e.g. (stroke) and give details below.

1. Have you or any dependents to be covered been hospitalized, advised, diagnosed, or treated by a physician in the past 5 years for: (If box is checked yes, please circle the condition and provide details below)

A. Stroke, heart, circulatory, vascular disease or disorder, high blood pressure? ❑ **Yes** ❑ **No**

B. Cancer, tumors, Leukemia, Lupus or any other systemic disease? ❑ **Yes** ❑ **No**

C. Multiple Sclerosis, paralysis, arthritis, bone/joint/back and muscle disorders? ❑ **Yes** ❑ **No**

D. Asthma, Emphysema, respiratory and lung disorders? ❑ **Yes** ❑ **No**

E. Diabetes, pancreas, growth disorder, or endocrine disorder? ❑ **Yes** ❑ **No**

F. AIDS, tested positive for HIV, immune system disorders, blood disorders? ❑ **Yes** ❑ **No**

G. Hepatitis, liver disorder, digestive system disease or disorder, colon disorder, kidney, prostate, reproductive organs disorder, infertility? ❑ **Yes** ❑ **No**

H. Brain/seizure disorders, mental/emotional disorders, alcohol/drug/substance abuse or dependency? ❑ **Yes** ❑ **No**

I. Organ or bone marrow transplant? ❑ **Yes** ❑ **No**

2. Are you, your spouse, or any dependent to be covered currently pregnant? ❑ **Yes** ❑ **No**

3. Has any person to be covered taken any prescription medication in the past 12 months, had surgery in the past 12 months or had surgery recommended? ❑ **Yes** ❑ **No**

4. Have you used cigarettes or other tobacco products in the last 12 months? **Employee:** ❑ **Yes** ❑ **No**

Spouse: ❑ **Yes** ❑ **No**

If you answered YES to any of the above questions, please provide details below.

DETAILS OF MEDICAL HISTORY

Question#	Person/Who	Condition/Diagnosis	Treatment/Rx Prescribed	Treatment Date	Date of Recovery

List all medications taken currently or within the last 12 months by any person to be covered.

DETAILS OF MEDICATIONS

Person	Name of Medication	Dosage	Illness for which prescribed	Treatment Date	Currently taking?
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

I authorize any medical professional, hospital, other medical facility or medical provider to disclose to the HCSC and FDL (the Company) Underwriting Department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the date that you receive notice of the Company's decision on my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws. I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

Signature of Employee | Signature of Spouse | Date

FORT DEARBORN LIFE INSURANCE COMPANY

Waiver of Coverage

BlueCross BlueShield of Illinois

Please complete this form if you are waiving any coverage. If you are not declining any coverage, please do not complete this form.

Employer Name		Employee social security #:		
Employee Last Name	First Name			M I
Street Address	Apt. #	City	State	Zip Code

If you are declining health or dental coverage for yourself, your spouse or your children because of other coverage, you may in the future be able to enroll yourself, your spouse and/or your children in this plan, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new spouse or child as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and them, provided you request enrollment within 31 days of the marriage, birth, adoption or placement for adoption. ***I acknowledge that I, along with my spouse and/or children (if any), were provided an opportunity to enroll in my employer's Group Health, Life and Dental Insurance plans.***

I DO NOT WISH TO ENROLL FOR: (check all that apply)

Health Plans

❑ I do not wish to enroll for Health coverage. I hereby elect not to enroll in the Group Health Insurance plan for the reason indicated below and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made available with the Company.

Reason:
❑ Covered under spouse's employer-based health insurance plan (Please complete "Other Insurance Information" section below)
❑ Covered under a Medicare supplement plan
❑ Other (please explain) _____

Your signature is required below for any waiver of coverage.

BlueCare Dental Options

❑ I do not wish to enroll for Dental coverage.

Your signature is required below for any waiver of coverage.

Fort Dearborn Life (FDL)

❑ I do not wish to enroll for Life coverage.
❑ I do not wish to enroll for Short Term Disability coverage.

Your signature is required below for any waiver of coverage.

If you are waiving any or all coverages offered, please remember to complete the "not enrolling" boxes for the coverage types you are waiving. Your signature is required for any waiver of coverage.

Other Insurance Information: Complete ONLY if you have other group coverage.

If you or any of your family members have other group coverage please complete the following section. Check all that apply.

Health coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other	Policy Number _____	❑ Single ❑ Family
Name of Insured:	SSN: __ __ __ / __ __ /__ __ __ __	Date of Birth: ___/___/_____
Employer Name:	Name and Address of Insurance Company:	
City	State / Zip	Telephone #

Dental coverage for: ❑ Self ❑ Spouse ❑ Dependent Child ❑ Other	Policy Number _____	❑ Single ❑ Family
Name of Insured:	SSN: __ __ __ / __ __ /__ __ __ __	Date of Birth: ___/___/_____
Employer Name:	Name and Address of Insurance Company:	
City	State / Zip	Telephone #

Signature of Employee: _____ Date: _____