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______________ (e.g., marriage)) ❑ Late

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

Group and Section Number	Employee Social Security #
P60860	___ ___ ___/___ ___/___ ___ ___ ___
Effective Date	**Date of Employment**
___ ___/___ ___/___ ___ ___ ___	___ ___/___ ___/___ ___ ___ ___

Employer Name: Oregon Community Unit School District # 220

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 ❑ BlueChoice 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: Oregon Community Unit School District # 220

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

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: Oregon Community Unit School District # 220			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: ____________

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