







**BlueCross BlueShield** of Illinois

A Division of Health Care Service Corporation, a Mutual Legal Reserve Company

App  
Social Secur  
Member II

300 East Randolph Street, Chicago, IL 60601 • 800-477-2000

# Sign Up for a **2026 Health** for You and Your Family.



You can sign up with Blue Cross and Blue Shield of Illinois, a Corporation, a Mutual Legal Reserve Company, an Independent Blue Shield Association (herein called BCBSIL), by visiting **BCBSIL.com**. We are working with an independent, authorized BCBSIL agent for more information on the last page.

## Help us process your Application

**If applying during Open Enrollment, leave page 3 blank except for name and address.** If you are applying outside annual Open Enrollment. Check **bcbsil.com** for a Special Enrollment Period before filling out this Application. To receive language or assistance call **855-710-6984**.

### **BE SURE TO:**

- Download and follow the Application Checklist at **bcbsil.com/app-checklist**.
- Include name and SSN at the top of all 12 pages.
- Answer **all** questions that apply to you and any dependents.
  - Print all answers in **black ink**. Pencil will not be accepted.

- Cross out **any answer you wish to change** and add your initials by the new
- Complete the Application for the Primary Applicant and all **current and new** dependent existing plan. If you need more dependent sections, please download and complete any overflow page(s) when you submit your Application. See **bcbsil.com/more**
- Include the **first month's payment**, or complete the payment details on page 11 to make monthly payments.
- Sign the Application everywhere a signature is required (pages 7, 8, 10 and 12).
  - use. Fax to **800-279-7419**.
  - If the primary applicant is a minor child, or an individual legally unable to sign, a representative should make all signatures.
- Once you have submitted your application you can track its progress and see what status **bcbsil.com/application-tracker**. You will receive an email with an access code once your application has been received.

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UN65-APP-Off-EX-2026

**1 of 12**

**We MUST**

# What do you want to do?

Appli

- Become a **NEW** member.
- CHANGE** my 2026 health plan.
- ADD** a dependent to my current health plan.
  - **You may add a newborn within 60 days of birth by calling 800-538-88**
  - **If including dependent parent(s), they must be a dependent parent (**
  - and must live in the plan service area.**

## How we will contact you.

If you want to get information from us electronically, we must have your email address. **agree we may send your policy information electronically**, such as policy kit. This electronic delivery will continue through any policy renewals or changes.

You can change to paper delivery at any time with no penalty. To make or change you may:

- Update your preferences and contact information at **mybam.bcbsil.com**.

**OR**

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. versions of Chrome, Firefox, Microsoft Edge or Safari.

## Will you use a reimbursement a

Are any of the applicants purchasing this plan using an Individual Coverage Health (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEH

**If yes, please complete the below.**

Select one:  ICHRA  QSEHRA

**Effective Date of the ICHRA or QSEHRA**

**Monthly Contrib**

**Employer Name**

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UN65-APP-Off-EX-2026

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**We MUST**

# Signing up outside Open Enrollment?

Appli



**If you are signing up during Open Enrollment, enter y then skip to the next page. You can also apply online**

## DO YOU QUALIFY FOR SPECIAL ENROLLMENT?

You may sign up for coverage during a Special Enrollment Period. An SEP is a chan

- **You must apply within 60 days before or after the qualifying life event,**
- Check more than one event if more than one happened to you.
- **You must give us valid proof of a qualifying life event with this Applicat**
  - BCBSIL will review this proof to confirm that you qualify for an SEP.
  - Without valid proof, we **cannot** process your form or sign you up for a healt
- Once your plan has been issued, your SEP cannot be re-used to apply for a diffi

Details about documents you need to provide are at [bcbsil.com/sep](https://bcbsil.com/sep). Please cont call BCBSIL at **800-477-2000** for examples of proof we can accept.

- 1.** My dependent(s) and/or I lost Minimum Essential Coverage as of this date. Fo
- For reasons beyond my control (not including reasons like failure to pay my disregard on my part for the plan's rules).<sup>1</sup>
  - Because I turned age 26 (or 30 if an unmarried military veteran).<sup>1,2</sup>
  - Because the plan holder became eligible for Medicare.<sup>1</sup>
  - Because the plan holder died.<sup>3</sup>
  - Because I lost my job, I lost hours, my employer stopped making payments: ended.<sup>1</sup>
  - Because someone on my plan was legally separated or divorced.<sup>1</sup>
  - Because my plan stopped covering people in my situation.<sup>1</sup>

- 2.** Because I got married on this date.<sup>3</sup>

- 3.** Because I had a baby, adopted a child, had a child placed with me for adoptio or was ordered to cover a dependent through a court order as of this date.<sup>3</sup>

- 4.** Because there was a mistake when I signed up for my last health plan, or I ha previous health plan or issuer broke its contract with me as of this date.<sup>3</sup>

- 5.** Because someone on my plan had a change in income and lost advance payr

credit, cost-sharing reductions, or Medicaid, or my last non-Marketplace plan as of this date.<sup>1</sup>

**6.** Because I got new health plan options when I moved on this date.<sup>1</sup>

**7.** Because my current plan ends on a date other than December 31, which is the

**8.** Because my employer offered to help with the cost of coverage either through Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Arrangement (QSEHRA). **Select one:**  **ICHRA**  **QSEHRA**

**a.** My employer is newly offering participation in an ICHRA or QSEHRA as a

**b.** I am a new employee and my employer is offering participation in an ICHRA or

**9.** Because of an allowed reason I do not see on this list that happened on this date (Please work with your agent or contact our sales center at **800-477-2000**.)<sup>1</sup>

<sup>1</sup> You must apply within 60 days before or after the qualifying life event.

<sup>2</sup> A dependent covered under a parent's Marketplace plan has until December 31 of the

<sup>3</sup> You must apply within 60 days after the qualifying life event.

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# Tell us about you.

Appli

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

<b>PRIMARY APPLICANT<sup>1</sup> (Who should be listed first on the health plan)</b>			
<b>First Name</b>		<b>Middle Initial</b>	<b>Last Name</b>
<b>Social Security Number</b>			<b>Sex</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Do you prefer to speak a language other than English?</b> <input type="checkbox"/> Y <input type="checkbox"/> N If YES, what language? _____		<b>Do you prefer to read a language other than English?</b> <input type="checkbox"/> Y <input type="checkbox"/> N If YES, what language? _____	
<b>Within the past six months, have you used tobacco?<sup>2</sup></b> 4 or more times per week for ceremonial uses <input type="checkbox"/> Y <input type="checkbox"/> N If YES, when did you last use tobacco? _____			
<b>Home Address</b>		<b>City</b>	
<b>Mailing Address</b> (if different than home address)		<b>City</b>	
<b>What is the best phone number to reach you?<sup>3</sup></b> _____			
<p>By providing your mobile phone number on this Application, you agree to receive a text message from BCBSIL, including from third-party vendors or providers directly contracted by BCBSIL to provide additional information about health plan products, benefits and programs at <a href="http://mybam.bcbsil.com">mybam.bcbsil.com</a>. Standard mobile phone and/or text message charges may apply and will be recurring. Frequency will vary. Consent is not a condition of purchase or enrollment.</p>			
<b>Email Address<sup>3,4</sup></b>			
<b>For BlueCare Direct<sup>SM</sup> or Blue Precision HMO<sup>SM</sup></b>			
<b>Medical Group Name</b>		<b>3-digit ID</b>	
<b>For MyBlue Plus<sup>SM</sup></b>			
<b>Primary Care Provider</b>		<b>10-character PCP ID</b>	
<small>See <a href="http://FindADoctorill.com">FindADoctorill.com</a> to find a Medical Group (BlueCare Direct, Blue Precision HMO, MyBlue Plus) or Primary Care Provider (MyBlue Plus).</small>			

See [FINDADOCTOR.COM](http://FINDADOCTOR.COM) to find a Medical Group (BlueCare Direct, Blue Precis not list a Medical Group or PCP above, BCBSIL will assign you a Medical Group Medical Group or PCP assignment may delay arrival of your member ID card. ) care received from a provider or Medical Group not listed on your ID card, or f Medical Group. See note about PCPs and OB-GYNs on page 6.

**OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following?**

Mexican     Mexican American     Chicano     Puerto Rican     C

**OPTIONAL: Are you or do you identify as any of the following? (check all th**

White     Black or African American     American Indian or Alaska Nati  
 Filipino     Japanese     Korean     Vietnamese     Other Asia  
 Guamanian or Chamorro     Samoan     Other Pacific Islander     C

<sup>1</sup> **If you are adding one or more dependents to your existing plan, please complete AND the Primary Applicant. Proof of ineligibility for Medicare is required if**

<sup>2</sup> Age 21 and older for tobacco use.

<sup>3</sup> Age 18 and older for mail, phone and email.

<sup>4</sup> You **must** provide your email address if you want to get information electronically or i

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# Tell us about you.

Appli

(PLEASE ANSWER FOR **EVERY** PERSON TO BE COVERED.)

**For more dependents, see [bcbsil.com/more-dependents-2026](https://bcbsil.com/more-dependents-2026)**

## **SPOUSE, PARTNER, DEPENDENT CHILD OR PARENT<sup>1,2</sup>**

<b>First Name</b>	<b>Middle Initial</b>	<b>Last Name</b>
<b>Relationship</b>	<b>Social Security Number</b>	
<b>Do you prefer to speak a language other than English?</b> <input type="checkbox"/> Y <input type="checkbox"/> N If YES, what language? _____	<b>Within the past six months, have</b> 4 or more times per week on average <input type="checkbox"/> Y <input type="checkbox"/> N If YES, when did you last use t	
<b>Mailing Address<sup>4</sup></b>	<b>City</b>	

**What is the best phone number to reach you?<sup>4</sup>**

By providing your mobile phone number on this Application, you agree to receive a from BCBSIL, including from third-party vendors or providers directly contracted b provide additional information about health plan products, benefits and programs **mybam.bcbsil.com**. Standard mobile phone and/or text message charges may a will be recurring. Frequency will vary. Consent is not a condition of purchase or enr

**Email Address<sup>4,5</sup>**

## **For BlueCare Direct<sup>SM</sup> or Blue Precision HMO<sup>SM</sup>**

<b>Medical Group Name</b>	<b>3-digit ID</b>
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## **For MyBlue Plus<sup>SM</sup>**

<b>Primary Care Provider</b>	<b>10-character PCP I</b>
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See **FindADoctorIL.com** to find a Medical Group (BlueCare Direct, Blue Precis not list a Medical Group or PCP above, BCBSIL will assign you a Medical Group Medical Group or PCP assignment may delay arrival of your member ID card. Y care received from a provider or Medical Group not listed on your ID card, or f

care received from a provider or medical group not listed on your ID card, or a Medical Group. See note about PCPs and OB-GYNs on page 6.

**If a dependent (other than spouse) is 26 or older, does dependent have a medical condition?**  
If YES, a Disabled Dependent Authorization Form is required. You can find the form on page 7.

**OPTIONAL: If you are Hispanic/Latino, do you identify as any of the following?**

Mexican     Mexican American     Chicano     Puerto Rican     Cuban

**OPTIONAL: Are you or do you identify as any of the following? (check all that apply)**

White     Black or African American     American Indian or Alaska Native  
 Filipino     Japanese     Korean     Vietnamese     Other Asian  
 Guamanian or Chamorro     Samoan     Other Pacific Islander     Other

<sup>1</sup> **If you are adding one or more dependents to your existing plan, please complete this form for the dependent AND the Primary Applicant. Proof of ineligibility for Medicare is required if the dependent is 65 or older.**

<sup>2</sup> "Spouse" includes domestic partners. Other dependents can be: 1) children up to age 26; 2) renewing, medically disabled adult children age 27 up; 3) dependent parents (spouse or partner) age 65 or older.

<sup>3</sup> Age 21 and older for tobacco use.

<sup>4</sup> Age 18 and older for mail, phone and email (if different from the Primary Applicant).

<sup>5</sup> You **must** provide your email address if you want to get information electronically.

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# Choose your health plan.

Appli



Your coverage will start on the 1st of the month, unless otherwise specified. Application must be received by BCBSIL within the defined period.

Please review your options below and **SELECT ONLY ONE OPTION:**

PLAN SELECTION	INDIVIDUAL DEDUCTIBLE
<input type="checkbox"/> BlueCare Direct Bronze <sup>SM</sup> Standard - Select Rx Copays with Advocate	\$7,500
<input type="checkbox"/> BlueCare Direct Silver <sup>SM</sup> Standard - Select Rx Copays with Advocate	\$6,000
<input type="checkbox"/> BlueCare Direct Gold <sup>SM</sup> Standard - Rx Copays with Advocate	\$2,000
<input type="checkbox"/> Blue Choice Preferred Bronze PPO <sup>SM</sup> 201	\$7,000
<input type="checkbox"/> Blue Choice Preferred Bronze PPO <sup>SM</sup> 202	\$4,500
<input type="checkbox"/> Blue Choice Preferred Bronze PPO <sup>SM</sup> 701	\$8,600
<input type="checkbox"/> Blue Choice Preferred Bronze PPO <sup>SM</sup> Standard - Select Rx Copays	\$7,500
<input type="checkbox"/> Blue Choice Preferred Silver PPO <sup>SM</sup> 203	\$1,500
<input type="checkbox"/> Blue Choice Preferred Silver PPO <sup>SM</sup> 303	\$1,500
<input type="checkbox"/> Blue Choice Preferred Silver PPO <sup>SM</sup> 801	\$4,300
<input type="checkbox"/> Blue Choice Preferred Silver PPO <sup>SM</sup> Standard - Select Rx Copays	\$6,000
<input type="checkbox"/> Blue Choice Preferred Gold PPO <sup>SM</sup> 204	\$1,200
<input type="checkbox"/> Blue Choice Preferred Gold PPO <sup>SM</sup> 901	\$2,000
<input type="checkbox"/> Blue Choice Preferred Gold PPO <sup>SM</sup> Standard - Rx Copays	\$2,000

PLAN SELECTION
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi Standard - S
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi Standard - S
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi
<input type="checkbox"/> Blue Precisi Standard - F
<input type="checkbox"/> MyBlue Plu:
<input type="checkbox"/> MyBlue Plu:
<input type="checkbox"/> MyBlue Plu: Select Rx Co
<input type="checkbox"/> MyBlue Plu:
<input type="checkbox"/> MyBlue Plu:
<input type="checkbox"/> MyBlue Plu:
<input type="checkbox"/> MyBlue Plu:

- You may get OB-GYN services from your Primary Care Provider (PCP) or an OB-GYN.
- You do not need a referral from your PCP to see an

You do not need a referral from your PCP to see an OB-GYN for preventive OB-GYN services.

- HMO plans will cover your OB-GYN visits only if your OB-GYN is in your plan network.
- You do not have to tell us your choice of OB-GYN before a preventive OB-GYN visit.

### Select RX Co

MyBlue Plu:

MyBlue Plu:

MyBlue Plu:  
Rx Copays

## "CATASTROPHIC" PLAN OPTION BELOW

### Here's what that means.

This plan covers essential health benefits, but generally only after you pay the high amount. **You qualify for this plan only if:**

- 1) you are under age 30 before the plan year begins, **or**
- 2) you have a waiver from the Health Insurance Marketplace®.  
Your Exemption Certificate Number is required to process your form. **Exemption**

**Blue Choice Preferred Security PPO<sup>SM</sup> 200**

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# Choose your dental plan.

Appli

The Affordable Care Act requires that we seek reasonable assurance from you that you have dental coverage for pediatric dental services (for children). The ACA considers coverage for pediatric dental services a part of every health benefit that every policy must provide, even if there is no one on the policy who is a child. Companies like BCBSIL offer this dental coverage for children through "Marketplace plans" which are also known as Dental Qualified Health Plans or Dental QHPs.



- For more information about these dental plan options, go to [www.bcbsil.com/dental](#).
- Dependents 19 to 26 are considered adults for dental coverage purposes.
- If you already have dental coverage with us, whatever you choose will replace your current dental coverage.

Please **SELECT ONLY ONE OF THE THREE OPTIONS:**

## **OPTION 1** Covers ADULTS WITH OR WITHOUT CHILDREN (choose one)



FOR  
ADULTS



OR  
ADULTS WITH  
CHILDREN

### **BlueCare Dental<sup>SM</sup>**

- BlueCare Dental 1A
- BlueCare Dental 1B
- BlueCare Dental 1C
- BlueCare Dental 1D

## **OPTION 2** Covers ONLY CHILDREN, UP TO AGE 19 (choose one) DO NOT CHOOSE if you chose a plan in option 1.



FOR CHILDREN  
ONLY

### **BlueCare Dental 4 Kids**

- BlueCare Dental 4 Kids
- BlueCare Dental 4 Kids

**OPTION 3** Choose this option only if you already have den

Check the box and sign here to tell us that you have what is known as a "Mark  
Our records will show that you have the Pediatric Dental essential health bene

**Note:** Checking this option will NOT result in a change or cancellat

**I/we already have coverage for pediatric dental essential health**

**Signature (REQUIRED if selecting Option 3)**



**If you do not make a choice,** you and each member on the policy will  
our Limited Dental QHP, so you will have the required pediatric dental be  
BCBSIL may find that pediatric dental coverage must be included with y  
you may owe an additional monthly payment for pediatric dental benef  
your first payment and will be included in your monthly bill.

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# Tell us how you will make your payments.

Appli



**Please be sure to read the important billing rules on**

- Your plan may be canceled if you don't make a payment.
- **A valid personal email address is REQUIRED for ele**
- **If billing emails sent to the email address provided removed from EFT and bills will be mailed via USPS**
- **If you are a current member paying your premium Payment Information, even if there are no changes.**

## FIRST PAYMENT

You may make your **first payment** by EFT, check or money order. Choose one:

- EFT (First payment will be taken from your account immediately.)  Check



**TIP:** Write the name of the Primary Applicant in the memo, different from name of account owner. **NOTE:** Use of a bus compliance with Third Party Payment Rules on page 9.

## MONTHLY PAYMENTS

You may make your **monthly payments** by electronic funds transfer (Auto Bill Pa Select your choice:

- EFT (Auto Bill Pay - valid email required)  Bill by email (valid email requirec

## PREMIUM PAYMENT INFORMATION (ALL fields required if payin

Please check one  Checking account  
 Savings account

Name(s) on account

Bank routing number (please verify)

Account numb

Email address

**AGREEMENT (See full Auto Bill Pay Terms of Use on page 9.)**

I confirm I want BCBSIL and/or its designee to take out monthly premium payment named above. Funds will be taken out on the last business day of the month before usual business day (any M-F) of the month is a holiday or other nonbanking day, full day. Withdrawals may be in the form of checks, share drafts or electronic debit on the institution named here to honor the same payments from my account.

**I have read and accept this agreement**

**Account owner's signature**

**Date**



Do not cancel any current coverage you may have until your new plan is effective.

Your first month's payment is due when you sign up. If you do not pay, **your coverage will not be in effect until we receive your payment.**

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# Important billing rules.

Appli

## **AUTO BILL PAY TERMS OF USE (email address required)**

**If you allow EFT, you understand and agree that BCBSIL and/or the company may take monthly payments from your checking or savings account in accordance with the following terms and conditions:**

- By signing up for Auto Bill Pay you authorize us and our service providers to store your selected payment method on a monthly basis unless you take timely steps to cancel. Payments will be charged to your selected payment method on the last day of the month preceding the billing date. If that day occurs on a weekend day or Federal holiday, the draft will be made prior. The amount you will be charged will be based on your premiums and other charges. You will be notified by email if the amount of your payment changes.
- If you would like to cancel Auto Bill Pay please log into your Blue Access for Members. Payment cancellations must be received no later than 3 days before the billing date. Cancellations are effective the next month.
- If your statement shows transfers that you did not make, including those made by ATM, you do not tell us within 60 days after the statement was sent to you, you may not get a refund if we can prove that we could have stopped someone from taking the money (if you were on a long trip or a hospital stay) kept you from telling us, we will extend the time to 90 days.
- If you have told us in advance to make regular payments out of your account, you agree to the following: Here's how:
  - Call us at the phone number found on the back of your member ID card or let us know how to receive your request 3 business days or more before the payment is scheduled.
  - If these regular payments may vary in amount, we will tell you, 10 days before the payment is made how much it will be.
  - If you order us to stop one of these payments 3 business days or more before the payment is made, so, we will be liable for your losses or damages.
- We may at any time and without notice amend these Auto Bill Pay Terms of Use. Your continued use of the Auto Bill Pay function after any such amendment or change(s). We may discontinue Auto Bill Pay functionality for any reason and with or without notice if terms or conditions are modified.

## **THIRD PARTY PAYMENT RULES**

**BCBSIL follows the premium payment process established by the Affordable Care Act and other federal requirements.**

1. BCBSIL accepts premium payments from the following third-party entities on behalf of its members:
  - A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act

- a. A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;
  - b. An Indian tribe, tribal organization or urban Indian organization; and
  - c. A local, state, or federal government program, including a grantee directed by its behalf.
2. BCBSIL may accept premium payments on behalf of enrollees from private, not-for-profit organizations:
    - a. For the entire coverage period of the enrollee's policy;
    - b. Based solely on the financial status of the enrollees;
    - c. Regardless of the financial status of the enrollee;
    - d. Regardless of the financial status of the enrollee's employer.
  3. BCBSIL may accept premium payments on behalf of enrollees from a Trust, Power of Attorney, or other legal arrangement.
  4. BCBSIL will not construe payments from an employer as impermissible third-party payment coordination services if the employer:
    - a. The employer facilitates premium payment collection through payroll deduction and the employer is not paying any part of the premium either directly or through a third party; or
    - b. The employee is participating in an Individual Coverage Health Reimbursement Arrangement (ICHRA) or a Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) offered by their employer.
  5. BCBSIL will accept payments on behalf of an enrollee directly from an employer or through a third party payment coordination service, when such payments are made using allowable amounts.

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# Tell us about other coverage.

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## COVERAGE YOU ARE REPLACING

Will this plan replace health coverage for 2026 you already have? **If yes, list all co terminate and replace with a plan from BCBSIL and read KNOW YOUR RIGI**

COVERED PERSON(S)	NAME OF INSURANCE COMPANY

## KNOW YOUR RIGHTS WHEN YOU REPLACE COVERAGE

If you chose "Yes" above, BCBSIL may NOT automatically cancel your old policy. Thi your current accident and health plan and replace it with a plan from BCBSIL. For y should know how this decision may affect the coverage available to you in a new p

1. You may want to ask the company that offers the plan you are replacing about y agent. This is your right. It is in your best interest. You should be sure you unde replace the coverage you have now.
2. If you still wish to cancel your present plan and replace it with new coverage, be questions on this Application about any person applying for coverage. If you lea may have a legal basis to deny any future claims and to refund your premium as force. Before you sign the completed Application, re-read it carefully to be sure 1

## OTHER COVERAGE YOU OR YOUR DEPENDENT(S) MAY HAVE

Does any person applying for coverage currently have, or did they previously have

- Coverage with BCBSIL?
- Health coverage with any other insurance company?
- Coverage under a tax-supported or government program, including Medicare?

**If yes, please provide details below:**

<b>Applicant Name</b>	<b>Name on Other Policy</b> (if differe
<b>Applicant Name</b>	<b>Name on Other Policy</b> (if differe

## Proxy Statement (OPTIONAL)

By purchasing a BCBSIL health plan, I become a member of Health Care Service Corporation. By signing this Proxy Statement, I ask the Board of Directors of HCSC to act on my behalf. I understand that:

- This permission will apply to any company that replaces HCSC.
- The Board of Directors may appoint someone to vote for me.

The annual meeting of members is scheduled to take place each year in the corporate headquarters (Chicago, IL 60601) on the last Tuesday of October at 12:30 p.m. Special meetings of members or any special meeting will be given within 30 to 60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

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**Primary Applicant's (your) proxy signature:**

**NOTE:** Whether you sign for proxy or not, you must sign on page 12 to complete this Application.

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**Print your name as you signed it:**

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# Please read and sign on next page.

## BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AN

- This Application is not coverage. Coverage will not begin until (1) the effective date of payment is made.<sup>1</sup>
- If I use an agent, they cannot accept risks or change the policies or rules of BCBSIL.
- If an agent helps me purchase a new or renew a health plan, BCBSIL may pay them for one month. My agents may also get bonus and marketing payments. These payments are not for my plan.
- If any person knowingly submits a false claim for payment of a loss or benefit or Application, coverage may be rescinded. This includes false claims or facts about my health. Coverage is canceled back to the first day it became effective. I will be given at least 30 days notice. My coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the state's department of health and state and federal laws and regulations. Rates are calculated based on age, tobacco use, and other factors. Rates are also used to calculate premiums for any dependents covered on my plan.
- I authorize any of the following people or organizations to share my health information with a representative:
  - Health professionals, hospitals, or clinics
  - Other health or health-related facilities
  - Government agencies
  - Pharmacy benefit managers, clearinghouses, or retail stores
  - Any other persons or firms required by law
- This information may include:
  - Copies of records about advice, care or treatment that were given to me or my dependents
  - Information about the prescription and use of drugs or alcohol
  - Information about mental illness
- BCBSIL may review and research its own records for information.
- BCBSIL will share collected information only as needed with medical entities.
- Information shared with my authorization may be re-shared by BCBSIL as allowed by law. If required, the person or agency getting the information will be responsible for protecting the information.
- This authorization is valid for two years from today, or until I cancel coverage.
  - I have the right to cancel the authorization at any time, in writing, by contacting BCBSIL.
  - I or anyone I authorize to represent me will receive a copy of this authorization.

- o Any cancellation will not affect the activities of BCBSIL before the date such
- I present any statements and answers on this Application as FACTS. To the best complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSIL and me.
- My agent (if I have one) and I confirm that I have read and understood the Application.
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Application.
- BCBSIL does not accept payments directly from third parties except from those
- If these rules are broken, any payments made by a third party will not be credited and payments may not be refunded to me. This may result in the cancellation of my plan.

**WARNING:** ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR MAKE A FALSE CLAIM FOR THE PROCEEDS OF A HEALTH PLAN CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION, IS SUBJECT TO PENALTIES AND MAY BE FOUND GUILTY OF A FELONY IN A COURT OF LAW.

<sup>1</sup> Some exceptions apply during a Special Enrollment Period. Check with your agent for details.

Blue Cross and Blue Shield  
a Mutual Legal Reserve Company, an Independent Member Company

# Did you work with an agent? Appli

## AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked th
- I provided written material to explain the benefits to the Applicant(s). This includ and any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes:

**Agent's Signature**

**Agent's Printed Name**

**Agent ID**

**Agent's Phone**

**Agent's Email**

# Please read and sign below. (REC

## YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PR

**Primary Applicant's Printed Name AND Signature**

**Parent or Legal Guardian of a Minor Child Printed Name AND Signature** (if child

**If this authorization is signed by a personal representative on behalf of an minor child), complete the following:**

**Personal Representative's Printed Name AND Signature**

# Send us your Application.

**TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSS**



- Sign your form.
- Send **ALL PAGES** of this form.
  - **INCLUDE EVEN BLANK PAGES.**
- If you are working with an agent, please include your agent's information above.
- Please
- If you listed a sign

**PLEASE SUBMIT THIS FORM BY:**

**MAIL**

Blue Cross and Blue Shield of Illinois, Attn: Individual Enrollment, PO Box

**FAX**

**800-279-7419**

**Questions?** If you have any questions, please call your agent or call 800-279-7419. Visit **discoverbcbsil.com** for frequently asked questions about our products.

Blue Cross and Blue Shield of Illinois is a Mutual Legal Reserve Company, an Independent Member of the Blue Cross and Blue Shield Association.

