BlueCross BlueShield of Illinois

P.O. Box 3236, Naperville, IL 60566-7236

APPLICATION FOR A CHANGE IN COVERAGE

Print all answers in **blue or black ink.** Pencil will not be accepted.

Please check *only one box* below to tell us why you are requesting a change in coverage.

☐ To become the Primary Policyholder of my health coverage because I am a dependent child, under age 26, or under age 30 if a military veteran, currently covered under a parent's or guardian's policy, and not eligible for permanent dependent status.

☐ To become the Primary Policyholder of my health coverage.
(If this request is due to the death of your spouse, please include a copy of the death certificate.)

☐ To choose a new Blue Cross and Blue Shield of Illinois health insurance plan with less comprehensive benefits.

PART 1 — COVERAGE APPLYING FOR (Please check appropriate boxes)

Note: To be eligible for an HSA plan, you must be 18 years of age or older.

☐ **SelectBlue®**
Deductible: ☐ $0 ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **SelectBlue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%

☐ **BlueChoice℠ Select**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%

☐ **BlueValue℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☐ $5,000
Level of Coverage: ☐ 100% ☐ 80%

☐ **BlueValue Advantage℠**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%

☐ **BlueChoice℠ Value**
Deductible: ☐ $250 ☐ $500 ☐ $1,000 ☐ $1,750 ☐ $2,500 ☐ $5,000
Level of Coverage: 80%

☐ **BlueEdge℠ Individual HSA***
Deductible:
☐ $1,200 for a single applicant or $2,400 for a family**
☐ $1,750 for a single applicant or $3,500 for a family
☐ $2,600 for a single applicant or $5,200 for a family
☐ $3,500 for a single applicant or $7,000 for a family
Level of Coverage: ☐ 100% ☐ 80%
*** The deductible amount will be adjusted automatically if the amount is lower than the amount required by law.*

☐ **BlueEdge℠ Individual HSA 5000***
Deductible:
$5,000 for a single applicant or $10,000 for a family
Level of Coverage: 100%

☐ **Include Maternity Coverage?**

PART 2 — PRIMARY APPLICANT INFORMATION

Name _____ County _____

Street Address _____ Home Phone (_____) _____

City _____ State _____ ZIP _____ Work Phone (_____) _____

E-mail Address _____ Sex ☐ M ☐ F Birthdate _____/_____/_____ (Mo./Day/Yr.)

SMOKING STATUS Have you or your spouse (if insured) smoked cigarettes or used tobacco in any form in the last 12 months?
You ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No

PRIMARY POLICYHOLDER OF CURRENT POLICY _____ Identification No. _____

Note: Social Security Numbers required only if moving to or from an HSA plan. Social Security No. _____-_____-_____

DEPENDENT CHILDREN

Note: You may only change coverage for children who are now covered under the current Blue Cross and Blue Shield of Illinois health insurance policy. ***If you wish to add additional dependent children (or a spouse), please call 1-800-538-8833 for the correct application.***

Do you wish to change coverage for children now insured on the current policy? ☐ Yes ☐ No If "**Yes**," complete the following:

Name of Unmarried Dependent Child	*Age*

BILLING ADDRESS If the billing address is different from above, please print it here: _____

* Please be reminded that Health Savings Accounts (HSAs) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross Blue Shield of Illinois, does not provide legal or tax advice, and nothing herein should be construed as legal or tax advice. Please consult your tax advisors for information regarding the tax consequences of specific health insurance plans or products.

PART 2 — (Continued)

1. Does any person applying for coverage currently have health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans? ☐ Yes ☐ No If "**Yes**," please complete the following:

Name(s) of all individuals covered: _____

Insurer Name(s): _____ Location / State: _____

Policy Effective Date: _____ Anticipated Policy Termination Date: _____

2. If "Yes" to question 1, is the issuance of this coverage replacing your existing coverage? ☐ Yes ☐ No

If "**Yes**", when is coverage to be replaced (mo./day/yr.)? _____/_____/_____

If "**No**", please explain _____

PART 3 — REPRESENTATIONS AND ACKNOWLEDGEMENTS

I apply for coverage as indicated for which I am eligible with Health Care Service Corporation which is herein called the Company.

I have been informed of the provisions of the Blue Cross and Blue Shield of Illinois health plans and the Medical Services Advisory (MSA®') Program.

I understand that the insurance plan applied for is not an employer-sponsored group health plan and it does not comply with state or federal small employer laws.

I represent that the information provided here as well as the statements included on my most recent application are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on my most recent application or on this Application for a Change in Coverage may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.

X _____ ____/____/____ **X** _____ ____/____/____

Primary Applicant's Signature **Date Signed** (Mo./Day/Yr.) **Spouse's Signature** *(only if spouse is currently covered and wishes to be covered under the new plan)* **Date Signed** (Mo./Day/Yr.)

Parent/Guardian Signature *(If Primary Applicant is UNDER the age of 18):*

X _____ ____/____/____

Date Signed (Mo./Day/Yr.)

Dependent(s) Signature(s) *(only if dependent is 18 or over, currently covered, and wishes to be covered under the new plan):*

X _____ ____/____/____ **X** _____ ____/____/____

Date Signed (Mo./Day/Yr.) **Date Signed** (Mo./Day/Yr.)

X _____ ____/____/____ **X** _____ ____/____/____

Date Signed (Mo./Day/Yr.) **Date Signed** (Mo./Day/Yr.)

X _____ ____/____/____ **X** _____ ____/____/____

Date Signed (Mo./Day/Yr.) **Date Signed** (Mo./Day/Yr.)

PART 4 — PROXY STATEMENT

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

X _____ ____/____/____ **X** _____

Primary Applicant's Signature *(optional)* **Date Signed** (Mo./Day/Yr.) **Print Your Name as You Signed It**

Questions? Call 1-800-538-8833. We're here to help.