Application for a Change in Coverage

Please complete and return this *entire* Application Booklet.

INDIVIDUAL AND FAMILY HEALTH INSURANCE

it just fits.

BlueCross BlueShield of Illinois

Here's How to REQUEST A CHANGE in Your Blue Cross and Blue Shield of Illinois Coverage...

Follow these three easy steps:

1. Check the appropriate box below.
2. Complete the attached Application.
3. Return this entire Application Booklet in the postage-paid envelope provided.

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

I am using this application to apply for the same plan I now have:

☐ To become the Primary Policyholder of my health coverage because I am a dependent child, between the ages of 19 and 25, 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.)

-or-

I am using this application to apply for a different plan than I now have:

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

☐ To change from an existing Children's Major Medical or Children's Alternative plan to a new Blue Cross and Blue Shield of Illinois health insurance plan with similar benefits.

Note: If you would like **more** benefits (which includes adding optional maternity coverage) or would like to add additional dependents (including a spouse) please call for the appropriate application.

When complete, simply mail this *entire* Application Booklet in the postage-paid envelope provided.

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

Application for a Change in Coverage

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

☐ **BlueEdge® Individual HSA**
Deductible: ☐ $1,000 for a single applicant or $2,000 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
Level of Coverage: 80%
Do you wish to continue optional maternity coverage you have on your current plan? ☐ Yes ☐ No ☐ Does not apply

☐ **BlueEdge® Individual HSA 5000**
Deductible: $5,000 for a single applicant or $10,000 for a family
Level of Coverage: 100%
Do you wish to continue optional maternity coverage you have on your current plan? ☐ Yes ☐ No ☐ Does not apply

PART 2 — PRIMARY APPLICANT INFORMATION

A. PRIMARY APPLICANT

Name_____ County_____
Street Address_____ Home Phone (_____) _____
City_____ State_____ ZIP_____ Work Phone (_____) _____
Social Security No._____-_____-_____ Sex_____ Birthdate _____ /_____ /_____

B. 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

C. PRIMARY POLICYHOLDER OF CURRENT POLICY_____ Social Security No. _____-_____-_____

D. 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*	*Full Time Student*
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No
_____	_____	☐ Yes ☐ No

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

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 (along with the provisions of the Mental Health Unit, if applicable).

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_____ _____ /_____ /_____
Primary Applicant's Signature Date Signed

X_____ _____ /_____ /_____
Spouse's Signature (only if spouse is currently covered and wishes to be covered under the new plan) Date Signed

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

X_____ _____ /_____ /_____
Date Signed

X_____ _____ /_____ /_____
Date Signed

X_____ _____ /_____ /_____
Date Signed

X_____ _____ /_____ /_____
Date Signed

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 meetings 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_____ _____ /_____ /_____
Primary Applicant's Signature Date Signed

X_____
Print Your Name as You Signed it

DO NOT DETACH. Please return this entire Application Booklet.