Please complete the following application and return to:

Via mail:
Doyle Rowe LTD
1301 W. 22nd Street
Suite 101
Oak Brook, IL 60523

Via fax:
630-379-0857

Via email:
bconroy@doylerowe.com

Questions? Contact Doyle Rowe LTD at 800-564-7227.

BlueCross BlueShield of Illinois

Applicant Name: _____

SSN#: _____

Member ID: _____

HOME OFFICE USE ONLY

2018 Individual Plan

New Application or Change in Coverage

To help us process your Application promptly, follow the instructions.

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

2 Make sure you personally sign the Application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature line.

3 If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information.

4 Please do not use correction fluid or tape.

Please submit your Application via mail or fax or by calling an agent of Blue Cross and Blue Shield of Illinois (BCBSIL) at 800-477-2000. Please complete the entire Application including the selection of a Payment/Billing Method in Sections D & E. Please note: If you are applying during a Special Enrollment Period (SEP), proof of a qualifying event must be included to complete your Application. Failure to provide appropriate SEP documentation will delay processing of the Application.

If you are working with a BCBSIL agent, please remember to include the name of your agent on the back of this Application.

APPLY ONLINE	bcbsil.com (Only available during Open Enrollment)
APPLY BY MAIL	Blue Cross and Blue Shield of Illinois - Attn: Individual Enrollment, P.O. Box 3236, Naperville, IL 60566–7236
APPLY VIA FAX	888-223-1988

If you have any questions, please call your agent or call BCBSIL toll-free at 800-477-2000.

If you are applying for coverage during a Special Enrollment Period or "SEP" (an opportunity to enroll outside of Open Enrollment). You may request coverage if you have experienced one or more of the qualifying life events listed below during the last 60 days (check all that apply). **You must provide acceptable proof of a qualifying event with this Application.** BCBSIL will review this proof to verify your eligibility for a SEP. Failure to provide acceptable proof with this Application of a qualifying event will delay or prevent the processing of your Application and enrollment in coverage. Please call your agent or BCBSIL at 800-477-2000 for examples of acceptable proof of these qualifying events.

	DATE OF EVENT
☐ 1. I and/or my dependent(s) lost Minimum Essential Coverage:[1] ☐ Involuntary loss due to reasons other than non-payment of premium or rescission on: ☐ Due to reaching the maximum age, legal separation, divorce, or death of the policyholder, as of: ☐ I am no longer eligible for my prior health insurance plan due to termination of employment, reduction in number of hours of employment or loss of employer contribution toward my premiums, or I have exhausted my COBRA benefits as of: ☐ I am no longer residing or living in my prior health insurance plan's HMO service area as of: ☐ I have a claim that would meet or exceed a lifetime limit on all benefits as of: ☐ I have lost coverage because my plan no longer offers benefits to the class of similarly situated individuals as of: ☐ I have lost coverage through my group HMO because I no longer reside or work in the service area and no other package is available as of:	
☐ 2. I gained or became a dependent due to marriage on:	DATE OF EVENT
☐ 3. I gained or became a dependent due to birth, adoption, placement for adoption, foster care or court-order on:	DATE OF EVENT
☐ 4. An error occurred in my previous health plan enrollment, or I have adequately demonstrated that my previous health plan or issuer substantially violated a material provision of its contract with me, as of:	DATE OF EVENT
☐ 5. The Health Insurance Marketplace has determined that I or my dependents am/are newly eligible or ineligible for payments of the advanced premium tax credit, or have a change in cost-sharing eligibility, or misconduct by a non-Marketplace entity as of:	DATE OF EVENT
☐ 6. I gained access to new health plan options because of a permanent move on:	DATE OF EVENT
☐ 7. My current policy is ending on a date other than December 31st, which is:[1]	DATE OF EVENT
☐ 8. Other qualifying event. If you do not see your circumstance listed, please work with your agent or contact our sales center at 800-477-2000.	DATE OF EVENT

[1]Can apply 60 days in advance.

Section A: Applicant(s) (Continued)

Applicant Name: ______________________

SSN#: ______________________

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX [M] [F]	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? [Y] [N] IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES [Y] [N] IF YES, PLEASE PROVIDE DATE OF LAST USE:	IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN ☐ CUBAN ☐ OTHER ______		
RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER ______				
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)			COUNTY	
PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS			
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) [Y] [N] IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX [M] [F]	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? [Y] [N] IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES [Y] [N] IF YES, PLEASE PROVIDE DATE OF LAST USE:	IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN ☐ CUBAN ☐ OTHER ______		
RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER ______				
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)			COUNTY	
PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS			
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) [Y] [N] IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

FIRST NAME, MIDDLE INITIAL, LAST NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	SEX [M] [F]	DATE OF BIRTH
DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? [Y] [N] IF YES, PLEASE SPECIFY:	*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE EXCLUDING RELIGIOUS OR CEREMONIAL USES [Y] [N] IF YES, PLEASE PROVIDE DATE OF LAST USE:	IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) ☐ MEXICAN ☐ MEXICAN AMERICAN ☐ CHICANO/A ☐ PUERTO RICAN ☐ CUBAN ☐ OTHER ______		
RACE (OPTIONAL—CHECK ALL THAT APPLY) ☐ WHITE ☐ BLACK OR AFRICAN AMERICAN ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ ASIAN INDIAN ☐ CHINESE ☐ FILIPINO ☐ JAPANESE ☐ KOREAN ☐ VIETNAMESE ☐ OTHER ASIAN ☐ NATIVE HAWAIIAN ☐ GUAMANIAN OR CHAMORRO ☐ SAMOAN ☐ OTHER PACIFIC ISLANDER ☐ OTHER ______				
*MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)			COUNTY	
PRIMARY PHONE CELL ☐ LANDLINE ☐	EMAIL ADDRESS			
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) [Y] [N] IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED:		

* Age 18 and over.
** Services must be provided by Primary Care Physician within the Medical Group selected.
† The designation of spouse shall include domestic partners.

Section D:
Initial Premium Payment Information

Applicant Name: _____

SSN#: _____

Note: Do not cancel any current coverage you may have until your Application is approved and your new plan is effective.

Please select one of the following Premium Payment options for your Application to be processed.

BANK DRAFT

Payment will be drafted upon receipt of this Application. You must complete the Authorization Agreement below.

☐ ONE-TIME BANK DRAFT

AUTHORIZATION AGREEMENT

Required for Bank/Financial Institution Draft Payments Only

I request and authorize BCBSIL and/or its designee to obtain payment of monthly premium amounts becoming due on the last day of the month prior to the following month's coverage by initiating charges from my checking or savings account in the form of checks, share-drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same from my account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day. If an ACH Transaction from my account is rejected for Non-Sufficient Funds (NSF), I understand that BCBSIL may at its discretion attempt to process the charge again within 30 days. I also understand that both the Financial Institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To change the Financial Institution these payments are paid from, I understand that I will need to provide at least 15 days advance notice to BCBSIL by telephone prior to a scheduled withdrawal date.

Please complete the following – print or type information

I authorize BCBSIL to deduct the premium payments from my checking or savings account.

Please ensure adequate funds are available at the time of Application. BCBSIL is not responsible for fees incurred due to insufficient funds.

PLEASE CHECK ONE ☐ CHECKING ACCOUNT ☐ SAVINGS ACCOUNT	NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT	
BANK TRANSIT NUMBER	DEPOSITOR'S ACCOUNT NUMBER	
☐ I HAVE READ AND ACCEPT THE ABOVE AGREEMENT		
DEPOSITOR'S SIGNATURE	DATE	RELATIONSHIP TO APPLICANT

OTHER PAYMENT METHOD

FIRST MONTH PREMIUM AMOUNT OF $_____ ENCLOSED

☐ CHECK ☐ MONEY ORDER

NOTE: Cashing of the Premium Payment does not constitute approval of this Application. If this Application is not approved, the Premium Payment will be returned to the Primary Applicant and neither the Primary Applicant nor any other person applying for coverage under this Application shall be entitled to benefits or coverage.

Policy on third-party payments. BCBSIL only accepts premium and cost-sharing payments from: (1) the Applicant; (2) the Applicant's family; (3) Required Entities (the entities the law requires BCBSIL to accept premium and cost-sharing payments from, which currently are Ryan White HIV/AIDS programs, under title XXVI of the Public Health Service Act, Indian tribes, tribal organizations and urban Indian organizations; and State and Federal government programs, as described in 45 C.F.R. § 156.1250); and (4) private non-profit foundations that make premium or cost-sharing assistance available to the Applicant: (a) for the entire coverage period of the Applicant's Contract, (b) regardless of the Applicant's health status, and (c) cannot condition assistance on enrollment with a particular issuer or in a particular benefit plan. BCBSIL does not accept premium and cost-sharing payments from any other third party. A violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to the Applicant's account or coverage, which may result in the termination or cancellation of coverage.

In addition, I understand that the coverage for which I am applying is not an employer-sponsored group health insurance plan and is not intended, in any way, to be an employer-sponsored group health insurance plan. I certify that my employer, if any, will not contribute any part of the premium, or provide reimbursement for any part of the premium for this coverage, now or in the future.

When you renew BCBSIL coverage or reenroll by selecting a new product, you will need to be current on your premium payments. Any past due premium payments for coverage we provided will be due at the beginning of the new plan year in addition to current premium charges. New coverage will not be effective until all such payments are made.

Section F: Proxy Statement

Applicant Name: _____

SSN#: _____

PROXY STATEMENT

PROXY STATEMENT

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 (300 E. Randolph St., Chicago, IL 60601) 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.

PRIMARY APPLICANT'S PROXY SIGNATURE (OPTIONAL): YOU MUST ALSO SIGN IN "SECTION H".	DATE
PRINT YOUR NAME AS YOU SIGNED IT:	

Section G: Other Coverage Information

OTHER COVERAGE INFORMATION

DOES ANY PERSON APPLYING FOR COVERAGE CURRENTLY HAVE, OR DID THEY PREVIOUSLY HAVE WITHIN THE LAST 5 YEARS, BCBSIL COVERAGE, OR HEALTH OR MAJOR MEDICAL INSURANCE COVERAGE WITH ANY OTHER INSURER, OR COVERAGE UNDER A TAX SUPPORTED OR GOVERNMENT PROGRAM, INCLUDING MEDICARE, TO THE EXTENT PERMITTED BY LAW, EITHER AS A PRIMARY INSURED, SPOUSE OR AS A DEPENDENT? [Y] [N]
IF "YES," PLEASE COMPLETE THE FOLLOWING:

APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)
APPLICANT NAME	NAME ON PREVIOUS POLICY (IF APPLICABLE)	MEMBER/GROUP NUMBER (OPTIONAL)

REPLACEMENT OF COVERAGE

WILL THIS INSURANCE REPLACE ANY HEALTH INSURANCE CURRENTLY IN FORCE? [Y] [N]
IF "YES," READ THE STATEMENT BELOW AND COMPLETE THE FOLLOWING:

LIST ALL COVERAGE THAT WILL BE REPLACED

INSURED	NAME OF COMPANY	POLICY NUMBER	TERMINATION DATE

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If "Yes" is indicated above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by BCBSIL. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new contract.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
2. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this Application concerning any person applying for coverage. Failure to include all material information on any Application may provide a basis for BCBSIL to deny any future claims and to refund your premium as though your contract had never been in force. After the Application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
3. It is recommended that you not terminate your present contract until you are certain that your Application for the new contract has been accepted by BCBSIL.

Section I: Agent Information

Applicant Name: _____

SSN#: _____

AGENT'S CERTIFICATION

Agent's Certification: I certify that I sent the Application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given. I further certify that I have no knowledge of any other medical information about the Applicant(s) not contained in this Application and that written material explaining the benefits, exclusions, and provisions of the Contract was sent to the Applicant(s). I certify that I have delivered the required Outline of Coverage, and if requested, the Disclosure Statement.

AGENT INFORMATION (if applicable)

AGENT'S SIGNATURE	DATE	AGENT ID	P&C CROSS REFERENCE
PRINT AGENT'S NAME	AGENT'S PHONE		AGENT'S FAX
AGENT'S EMAIL			

THANK YOU FOR APPLYING.

Please include all necessary materials when submitting this Application.
If legal guardian, please enclose signed court decree. Visit **bcbsil.com/member** and click on **What to Expect** for frequently asked questions about membership, payments, and benefits.