



# ADMINISTRATOR

## Insurance Enrollment / Change Application

**For Office Use Only**

Effective Date	Employment Date	Termination Date N/A
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**EMPLOYEE INFORMATION - All fields are required. Please print.**

Social Security Number	Medicare HIC # (if applicable)
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**Employer Name**  

**Glenview School District**

Employee Name	Birthdate
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Employee Address	City	State	Zip
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Phone Number	Email Address	Gender [ ] Male [ ] Female	Marital Status [ ] S [ ] M [ ] D [ ] W
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**PLAN INFORMATION**

**Enrollment Type**  
 Open Enrollment     Late Applicant     Special Open Enrollment     Change from previous coverage

**Blue Cross / Blue Shield MEDICAL Plan**  
 PPO Plan 1000     PPO Plan 1250     HDHP 3300  
 HMO A (HMO Illinois)     HMO B (Blue Advantage)

**Blue Cross / Blue Shield MEDICAL Plan Coverage Level**  
 Employee Only     Employee + Spouse     Employee + Child     Family

**BCBSIL DENTAL Plan Coverage Level**  
 Employee Only     Family

**Add Dependents** Effective Date: \_\_\_/\_\_\_/\_\_\_\_\_  
 Marriage     Newborn     Adoption/Placemen     Legal Guardianship     Other:

**Cancel Dependents** Effective Date: \_\_\_/\_\_\_/\_\_\_\_\_  
 Divorce     Age Limit     Other:

**Cancel (Check all that apply)** Effective Date: \_\_\_/\_\_\_/\_\_\_\_\_  
 Terminate Coverage     Waive Coverage     Leave/Layoff     Other:

**If electing HMO, the Medical Group and/or PCP information for all dependents is required.**

You must indicate your Primary Care Physician (PCP) and Woman's Principal Health Care Provider (WPHCP) (if applicable). A Woman's Principal Health Care Provider may be seen for care without referrals from your Primary Care Physician, however your Primary Care Physician and your Woman's Principal Health Care Provider must be affiliated with or employed by your Participating IPA/Participating Medical Group.

PCP's Medical Group #	PCP's Medical Group Name	PCP's Name	PCP's Provider #
WPHCP's Medical Group #	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #

**Is this employee an existing patient of the Primary Care Provider?**     Yes     No

**DEPENDENT INFORMATION**

Effective 1/1/09, by Federal Regulation, Employees and Dependents must provide their SSN to be enrolled for benefits.

If electing HMO, please provide PCP and WPHCP (if applicable) info for each dependent.

Dependent Name	Relationship	Gender	Birthdate	Social Security Number

PCP's Medical Group	PCP's Medical Group Name	PCP's Name	PCP's Provider #
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WPHCP's Medical Group #	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
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Dependent Name	Relationship	Gender	Birthdate	Social Security Number

PCP's Medical Group #	PCP's Medical Group Name	PCP's Name	PCP's Provider #
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WPHCP's Medical Group #	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
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Dependent Name	Relationship	Gender	Birthdate	Social Security Number

PCP's Medical Group #	PCP's Medical Group Name	PCP's Name	PCP's Provider #
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WPHCP's Medical Group #	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
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Dependent Name	Relationship	Gender	Birthdate	Social Security Number

PCP's Medical Group #	PCP's Medical Group Name	PCP's Name	PCP's Provider #
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WPHCP's Medical Group #	WPHCP's Medical Group Name	WPHCP's Name	WPHCP's Provider #
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**OTHER INSURANCE INFORMATION**Do you or any of your dependents have other group medical coverage or Medicare?  Yes (please provide info below)  NoHave Certificate of Coverage?  Yes  No  N/A - I have been covered under this Medical plan for 12 or more consecutive months

If blank, plan will assume "No"

Name of Individual with other coverage	Other Insurance Carrier or TPA
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Address of Carrier or TPA, City, State, Zip	Effective Date of coverage:
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**WAIVER OF COVERAGE**

I am waiving coverage under the following plans:

 Medical  Dental

If declining medical coverage due to other coverage, please choose below.

 Medicare (Employee) coverage  Parents' coverage  Spousal coverage  COBRA Medicaid or other State/Federal coverage (ex: VA)  Other: \_\_\_\_\_**CERTIFICATION**

If you refuse coverage for yourself, you automatically refuse that coverage for any dependents. If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within 30 days after your other coverage ends. Also, you must indicate the reason for declining enrollment to later be eligible under the special enrollment rules. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. The pre-existing conditions limitation is stated in the summary plan description. You and/or your dependents have the right to demonstrate creditable coverage by requesting a certificate of coverage from your prior plan or insurer. If necessary and requested, this plan will assist you in obtaining this certificate.

By signing below, I certify the above information is true and correct.

Signature	Date
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