SUPPORT STAFF

Insurance Enrollment / Change Application

For Office Use Only

Effective Date	Employment Date	Termination Date
		N/A

EMPLOYEE INFORMATION - All fields are required. Please print.

Social Security Number	Medicare HIC # (if applicable)

Employer Name

Glenview School District #34

Employee Name	Birthdate

Employee Address	City	State	Zip

Phone Number	Email Address	Gender	Marital Status
		[ ] Male [ ] Female	[ ] S [ ] M [ ] D [ ] W

PLAN INFORMATION

Enrollment Type

[ ] New Enrollee / Open Enrollment [ ] Late Applicant [ ] Special Open Enrollment [ ] Change from previous coverage

Blue Cross / Blue Shield MEDICAL Plan

[ ] PPO Plan 1000 [ ] PPO Plan 1250 [ ] HDHP 3000

[ ] 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/Placement [ ] Legal Guardianship [ ] Other:

Cancel Dependent 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 Number	PCP's Medical Group Name	PCP's Name	PCP's Provider #
WPHCP's Medical Group Number	**WPCHP'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 complete PCP and Women's Principal Health Care Provider (WPHCP) info for each dependent (if applicable).

Dependent Name	Relationship	Gender	Birthdate	Social Security Number

PCP's Medial Group #	PCP's Medical Group Name	PCP's Name	PCP's Provider #
WPHCP's Medical Group #	**WPCHP's Medical Group Name**	**WPHCP's Name**	**WPHCP's Provider #**

Dependent Name	Relationship	Gender	Birthdate	Social Security Number

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

Dependent Name	Relationship	Gender	Birthdate	Social Security Number

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

Dependent Name	Relationship	Gender	Birthdate	Social Security Number

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 #**

OTHER INSURANCE INFORMATION

Do you or any of your dependents have other group medical coverage or Medicare? [ ] Yes (please provide info below) [ ] No

Have 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
Address of Carrier or TPA, City, State, Zip	**Effective Date of coverage:**

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 of Employee **Date**