

BENEFIT PROGRAM APPLICATION CHANGE FORM

(Applicable to Insured Group Accounts of 2-150 lives)

Employer Name: (Specify the Employer Name on the Benefit Program Application. "BPA")		
Account Number (<i>BlueStar</i>):	Group Number:	Section Number:
Effective Date of Change(s) specified below: (First or fifteenth of the month, whichever corresponds to Renewal Date)		

It is understood and agreed that pursuant to the Policyholder's request for change(s), the Benefit Program Application ("BPA") is revised as specified below. Please complete only those items below that constitute a change to the information specified on the BPA.

1. Miscellaneous Information:

Street Address:	City:	Zip:
Subsidiaries:		
Affiliated Companies:		
Administrative Contact:	Phone:	Fax: Email:

2. Eligibility Date:

<input type="checkbox"/> The date of employment.	<input type="checkbox"/> The day of employment.
<input type="checkbox"/> The first day of the month following the date of employment.	
<input type="checkbox"/> The day of the month following month(s) days of employment.	

3. Employer Contribution -

Medical Coverage

<input type="checkbox"/> % for Employee Coverage	<input type="checkbox"/> % for Employee plus Spouse Coverage
<input type="checkbox"/> % for Employee plus Child(ren) Coverage	<input type="checkbox"/> % for Family Coverage
<input type="checkbox"/> 100% of the Employee Coverage Premium will be applied toward the Family coverage premium.	

Life, Accidental Death and Dismemberment (AD&D) and Short Term Disability Coverage (STD)

Type of Coverage:	Coverage Selected:	Employer Contribution:
<input type="checkbox"/> Life / AD&D	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> %
<input type="checkbox"/> Dependent Life	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> %
<input type="checkbox"/> STD	Yes <input type="checkbox"/> No <input type="checkbox"/>	<input type="checkbox"/> %



BlueCross BlueShield of Illinois

A Division of Health Care Service Corporation,
a Mutual Legal Reserve Company,
an Independent Licensee of the Blue Cross and Blue Shield Association



FORT DEARBORN LIFE
Insurance Company

The undersigned representative is authorized and responsible for purchasing insurance on behalf of the Group and has provided the information specified in this BPA Change Form. It is understood and agreed that the actual terms and conditions of the benefit program are those contained in the Group Policy. This BPA Change Form is subject to acceptance by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company ("HCSC"). Upon acceptance, this BPA Change Form shall be incorporated and made a part of the BPA and Group Policy. In the event of any conflict between the Request for Proposal ("RFP") submitted to the Group by the Sales Representative and the Group Policy, the provisions of the Group Policy shall prevail.

 HCSC Authorized Representative

 Signature of Authorized Purchaser

 District

 Title

 Date

Underwriting Authorization:

Internal Use Only	Date Approved:
	Underwriter Signature: