



APPLICATION FOR A CHANGE IN COVERAGE

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

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

- To become the Primary Policyholder of my health coverage because I am at least age 26, or at least age 30 if a military veteran, 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.
To choose a new Blue Cross and Blue Shield of Illinois health insurance plan with less comprehensive benefits.

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

- SelectBlue, SelectBlue Advantage, BlueChoice Select, BlueValue, BlueValue Advantage, BlueChoice Value, BlueEdge Individual HSA, BlueEdge Individual HSA 5000, Include Maternity Coverage. Includes deductible and coverage level options.

PART 2 - PRIMARY APPLICANT INFORMATION

Name, Street Address, City, State, ZIP, E-mail Address, County, Home Phone, Work Phone, Sex, Birthdate.

SMOKING STATUS Have you, your spouse or dependent child(ren) (if insured) smoked cigarettes or used tobacco in any form in the last 12 months? You Yes No Spouse or Dependent Child(ren) Yes No

PRIMARY POLICYHOLDER OF CURRENT POLICY

Identification No., Social Security No.

SPOUSE AND/OR DEPENDENT CHILD(REN)

Note: You may only change coverage for a spouse and/or dependent child(ren) who are now covered under the current Blue Cross and Blue Shield of Illinois health insurance policy.

Do you wish to change coverage for your spouse and/or dependent child(ren) now insured on the current policy? If "Yes," complete the following:

Table with columns: Name of Spouse and/or Dependent Child(ren), Age

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

\* Please be reminded that Health Savings Accounts (HSAs) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross Blue Shield of Illinois, does not provide legal or tax advice...

**PART 2 -- (Continued)**

1. Does any person applying for coverage currently have health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans?  Yes  No If "Yes," please complete the following:

Name(s) of all individuals covered: \_\_\_\_\_

Insurer Name(s): \_\_\_\_\_ Location / State: \_\_\_\_\_

Policy Effective Date: \_\_\_\_\_ Anticipated Policy Termination Date: \_\_\_\_\_

2. If "Yes" to question 1, is the issuance of this coverage replacing your existing coverage?  Yes  No

If "Yes", when is coverage to be replaced (mo./day/yr.)? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If "No", please explain \_\_\_\_\_

**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.

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 know that any fraudulent misstatements or omissions, or intentional misrepresentations of a material fact that are made on this application or any act or practice that constitutes fraud, will result in the cancellation of my or my spouse and/or dependent child(ren)'s coverage retroactive to the effective date of coverage subject to prior notification.

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Primary Applicant's Signature Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Spouse's Signature (only if spouse is currently covered and wishes to be covered under the new plan) Date Signed (Mo./Day/Yr.)

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

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date Signed (Mo./Day/Yr.)

**PART 4 -- PROXY STATEMENT**

**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 meeting 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 (optional) Date Signed (Mo./Day/Yr.)

X \_\_\_\_\_  
Print Your Name as You Signed It

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

Changes in state or federal law, or regulations or interpretations thereof, may change the terms and conditions of coverage.

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