BlueCross BlueShield of Illinois

Applicant Name: _____

SSN#: _____

Member ID: _____

Home Office Use Only

Sign Up for a **BlueCare Vision**℠ Plan for You and Your Family.

You can visit **coverageplusIL.com** to sign up. If you are working with a Blue Cross and Blue Shield of Illinois (BCBSIL) agent, be sure to include your agent's information on the final page.

TO HELP US PROCESS YOUR APPLICATION MORE QUICKLY, BE SURE TO:

- Answer **all** questions that apply to you.
- Answer **all** questions about legal dependents you are signing up.
- Include the first month's payment.
- Include details for how you want to make monthly payments.
- Sign the Application.
- Print all answers in **blue or black ink**. Pencil will not be accepted.
- **If you need to change any answers,** cross out what you are changing and add your initials by the new answer. Do not use correction fluid or tape.

EXCEPTED BENEFIT PLANS DISCLOSURE

This type of plan is NOT considered "minimum essential coverage" under the Affordable Care Act and therefore does NOT satisfy the individual mandate, if any, that you have health insurance coverage. If you do not have other health care coverage coverage, you may be subject to a tax penalty.

Please consult your tax advisor.

HOW MAY WE CONTACT YOU?

If you want to get information from us electronically, we **must** have your email address. **By listing an email address, you agree we may send your policy information electronically.** This electronic delivery will continue through any policy renewals or changes.

You can go back to paper delivery at any time with no penalty. To make or change your choices, you may:

- Register for or log in to your account at **coverageplusIL.com**.

OR

- Call Customer Service at the number on your member ID card.

Your documents can be viewed or printed using your computer or mobile device. The website may be accessed with most versions of Internet Explorer, Chrome or Firefox.

If any of the phone numbers I list in this form is a mobile phone, I agree that:	BCBSIL may call me or any dependents 18 years old or over with prerecorded or automated calls related to my vision coverage.	Y N
	BCBSIL may call me or any dependents 18 years old or over with information about new plans and benefits.	Y N

If any of the phone numbers I list in this form is for a home (landline) phone, I agree that:	BCBSIL may call me or any dependents 18 years old or over with information about new plans and benefits.	Y N

WHAT DO YOU WANT TO DO?

- ☐ Choose a **NEW** BCBSIL vision plan.
- ☐ **CHANGE** my BCBSIL vision plan.
- ☐ **ADD** a dependent to my current BCBSIL vision plan.[1]

[1] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**

Tell us about you.

(PLEASE ANSWER FOR **EACH** PERSON.)

Applicant Name: _____

SSN#: _____

PRIMARY APPLICANT (Who should be listed first on the vision plan?)

First Name, Middle Initial, Last Name	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N If YES, what language?

Do you prefer to read or write a language other than English? Y N If YES, what language?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

Are you or do you identify as (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 _____

Home Address - Street, City, State, ZIP Code

County

Mailing Address (IF YOU GET YOUR MAIL ELSEWHERE, LIKE A P.O. BOX)

What is the best phone number to reach you? ☐ Mobile ☐ Landline

Email Address[2]

SPOUSE OR DEPENDENT CHILD[3,4] (Who else do you want to be covered on your plan?)

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex M F	Date of Birth

Do you prefer to speak a language other than English? Y N If YES, what language?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)

☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other _____

Are you or do you identify as (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[1] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you? ☐ Mobile ☐ Landline

Email Address[2]

[1] Age 18 and older.
[2] If you want to get information from us electronically, we **must** have your email address.
[3] Up to age 26 unless medically disabled. Up to age 30 for unmarried military veterans.
[4] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**

Tell us about you. (DEPENDENTS[1], continued)

Applicant Name: ____________________

SSN#: ____________________

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N If YES, what language?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other ____________

Are you or do you identify as (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[2] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you? ☐ Mobile ☐ Landline	Email Address[3]

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N If YES, what language?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other ____________

Are you or do you identify as (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[2] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you? ☐ Mobile ☐ Landline	Email Address[3]

First Name, Middle Initial, Last Name	Relationship	Social Security Number	Sex ☐M ☐F	Date of Birth

Do you prefer to speak a language other than English? ☐Y ☐N If YES, what language?

If you are Hispanic/Latino, do you identify as any of the following? (OPTIONAL—check all that apply)
☐ Mexican ☐ Mexican American ☐ Chicano ☐ Puerto Rican ☐ Cuban ☐ Other ____________

Are you or do you identify as (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[2] - Street, City, State, ZIP Code (IF DIFFERENT THAN ABOVE)

What is the best phone number to reach you? ☐ Mobile ☐ Landline	Email Address[3]

[1] **If you are adding one or more dependents to your existing policy, please complete the application for all dependents and the Primary Applicant.**
[2] Age 18 and older.
[3] If you want to get information from us electronically, we **must** have your email address.

Choose your vision plan.

Applicant Name: _____

SSN#: _____

Please review your options below and **SELECT ONLY ONE OPTION:**

BlueCare Vision (For All Applicants)	EXAM WITH DILATION	FRAMES	CONTACT LENSES
☐ BlueCare Vision Basic℠	$0 Copay	Discounts Apply*	Discounts Apply*
☐ BlueCare Vision Standard℠	$10 Copay	$130 Allowance	$130 Allowance
☐ BlueCare Vision Premier℠	$10 Copay	$200 Allowance	$200 Allowance

* Discounts are not insurance. You should use your insurance coverage first.

Tell us about any medical coverage.

OTHER COVERAGE		
Do you currently have an individual BCBSIL policy? (Not through your employer) **If yes, please complete the following:**		Y N
Primary Applicant	**Member ID Number**	

Proxy statement (OPTIONAL)

By purchasing a BCBSIL vision plan, I become a member of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC). By signing this application, I ask the Board of Directors of HCSC to act on my behalf at all meetings of members of HCSC. I understand that:

- This permission will apply to any company that replaces HCSC
- The Board of Directors may appoint someone to vote for me

The annual meeting of members is scheduled to take place 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 if needed. Notice of any special meeting will be given within 30-60 days before the meeting.

My assignment of my member vote to the Board of Directors will be in effect:

- Until or if I cancel it in writing at least 20 days before any meeting of members, or
- Unless I attend and vote in person at any meeting of members

Primary Applicant's (your) proxy signature: **NOTE:** Whether you sign for proxy or not, you must sign on page 8 to complete this application.	**Date**
Print your name as you signed it:	

Important billing rules.

Applicant Name: _____

SSN#: _____

ELECTRONIC FUNDS TRANSFER (EFT) BILLING RULES

If you allow EFT, you understand and agree that BCBSIL and/or the company BCBSIL chooses to process payments may withdraw monthly payments from your checking or savings account in accordance with the terms below:

- Payments are due on the last day of the month before the month of coverage.
- Payment will be made as you choose on the next page.
- Your bank or credit union will process these payments.
- If the payment date falls on a nonbusiness day or a holiday, the payment will be taken on the next business day.
- Please make sure you have enough money in your account when you submit this Application. If a payment is denied for non-sufficient funds (NSF), BCBSIL may try to process the charge again at any time in the next 30 days. BCBSIL will not pay you back for any fees your bank or credit union charges you for not having enough money in your account.
- Both the bank or credit union and BCBSIL reserve the right to end this payment program or your participation in it if payment is denied for NSF. This means payments would not be made automatically anymore. Coverage may stop (claims would not be paid) if you do not pay your monthly bill.
- To change the bank or credit union these payments are paid from, you will need to give at least 15 days' notice to BCBSIL by telephone before a scheduled payment date.

THIRD PARTY PAYMENT RULES

BCBSIL accepts premium or cost-sharing payments for members from these four sources only:

1) You

2) Your family, or someone who has your Power of Attorney, a Legal Guardian or a Trust

3) Authorized Entities
Under the law, BCBSIL accepts payments from Authorized Entities. At this time, Authorized Entities include:
a) Ryan White HIV/AIDS programs, under Title XXVI of the Public Health Service Act
b) Indian tribes, tribal organizations and urban Indian organizations
c) State and Federal government programs as described in 45 C.F.R. § 156.1250.

4) Private nonprofit foundations that pay:
a) for the entire coverage period of your contract,
b) no matter your health status, and
c) no matter what company or benefit plan you choose

Payments made by a third party that is not shown above will not be accepted for your account. This may end or cancel the coverage.

I understand:
- My BCBSIL plan will not be a group vision plan sponsored by an employer.
- This coverage is not meant to be an employer-sponsored group vision insurance plan in any way.

I agree:
- My employer (if any) will not pay any part of my monthly bill or copays.
- My employer (if any) will not pay me back for these payments now or in the future.

PAST DUE PAYMENT POLICY

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

Tell us how you will make your payments.

Applicant Name: _____

SSN#: _____

Please be sure to read the important billing rules on the previous page.
Your plan may be canceled if you don't make a payment.

FIRST PAYMENT

You may make your **first payment** by Electronic Funds Transfer (EFT), check or money order. Select your choice:

☐ EFT (Payment will be taken from your account immediately.) ☐ Check ☐ Money order

First month premium payment information (if paying by EFT):

Please check one ☐ Checking Account ☐ Savings Account	**Name of depositor(s) if other than the Applicant**
Bank routing number	**Depositor's account number**

☐ **I have read and accept the below agreement**

Depositor's signature	**Date**	**Relationship to Applicant**

First month premium payment enclosed (if not paying by EFT):

☐ Check ☐ Money Order

MONTHLY PAYMENTS

You may make your **monthly payments** by Electronic Funds Transfer, or we can send you a bill by email or mail. Select your choice:

☐ EFT ☐ Bill by email[1] ☐ Bill by mail

Monthly premium payment information (if paying by EFT, if different from above):

Please check one ☐ Checking Account ☐ Savings Account	**Name of depositor(s) if other than the Applicant**
Bank routing number	**Depositor's account number**

☐ **I have read and accept the below agreement**

Depositor's signature	**Date**	**Relationship to Applicant**

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, sharedrafts, or electronic debit entries, and I request and authorize the Financial Institution named here to accept and honor the same from my account.

NOTE:

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

Your first month's payment is due when you sign up. If you are signing up for a new plan, your application will not be processed until we receive your payment.

[1] If you want to get information from us electronically, we **must** have your email address.

Please read and sign below.

Applicant Name: _____

SSN#: _____

BY COMPLETING AND SIGNING THIS FORM, I UNDERSTAND AND AGREE TO THE FOLLOWING:

- This Application is not coverage. Coverage will not begin until (1) the effective date of the policy and (2) the first month's payment is made.
- If I use an agent or broker, they cannot accept risks or change BCBSIL policies or rules.
- If an agent, producer or broker was helping me to purchase a vision plan, BCBSIL may pay the broker a commission and/or other payment. If I want more detail about any payment to the agent or broker, I should ask the agent or broker.
- If any person knowingly submits a false claim for payment of a loss or benefit or falsely misstates an important fact on this Application, coverage may be rescinded. This includes false claims or facts about me or any of my dependents. Rescission cancels the coverage back to the first day it became effective. I will be given at least 30 days' written notice before my coverage or that of my dependents is rescinded.
- My monthly premium will be calculated using factors approved by the State's Department of Insurance and other applicable State and Federal laws and regulations. Rates are calculated based on age and geographic rating factors. These factors are also used to calculate premiums for any dependents covered on my policy.
- Coverage will start on the plan effective date only if the first monthly payment is received in full before that date.
- I allow any of the following people or organizations to share my health information with BCBSIL or their authorized representative:
  - Health professionals, hospitals, or clinics
  - Other health or health-related facilities
  - Government agencies
  - Pharmacy benefit managers, clearinghouses, or retail stores
  - Any other persons or firms required by law
  - This information may include:
    - Copies of records about advice, care or treatment that were given to me and/or my dependents
    - Information about the prescription and use of drugs or alcohol (without limitation)
    - Information about mental illness
- BCBSIL may review and research its own records for information.
- BCBSIL will share collected information only as needed with medical entities to help manage my care.
- Information shared with my authorization may be re-shared by BCBSIL as allowed or required by law. If such sharing is required, the person or agency getting the information will be responsible for protecting it.
- This authorization is valid for two years from today, or until I cancel coverage.
  - I have the right to cancel the authorization at any time, in writing, by contacting BCBSIL.
  - I or anyone I authorize to represent me will receive a copy of this authorization upon request.
  - Any cancellation will not affect the activities of BCBSIL before the date such cancellation is received by BCBSIL.
- I present any statements and answers on this Application as FACTS. To the best of my knowledge and belief, they are true and complete. These facts are the basis of my Application.
- The Application will become a part of the contract between BCBSIL and me.
- My agent (if I have one) and I confirm that I have read and understood the Application.
- I have reviewed the details of the plan I chose.
- This individual or family plan is meant to be paid as my personal expense.
- Only I or a family member, or an allowed third party as outlined in the Application will pay BCBSIL directly.
- BCBSIL does not accept payments directly from third parties except from those listed on page 5 (family members, Required Entities, certain private nonprofit foundations).
- If these rules are broken, any payments made by a third party will not be credited to my account or coverage. These payments may not be refunded to me. This may result in the cancellation of my coverage for nonpayment.

WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE FOUND GUILTY OF A FELONY IN A COURT OF LAW.

Please read and sign below.

Applicant Name: _____

SSN#: _____

YOUR SIGNATURE MAKES THIS A CONTRACT IF/WHEN FULLY PROCESSED	
Primary Applicant's Signature	**Date**
If this authorization is signed by a personal representative on behalf of an individual (other than a parent for a minor child), complete the following:	
Personal Representative's Name (PLEASE PRINT)	**Relationship:**
Do you permit any other adult named on this form to answer questions about this form? ☐ Y ☐ N	

Did you work with an agent?

AGENTS, COMPLETE THIS SECTION (IF APPLICABLE)

I certify that:

- I provided the Application to the Applicant(s) for completion, or I personally asked the questions and recorded the answers as given.
- I provided written material to explain the benefits to the Applicant(s). This includes details about what may not be covered and any special details about their coverage.
- I have reviewed the required plan document(s) with the Applicant. This includes the Disclosure Statement(s) when requested.

Agent's Signature	**Date**	**Agent ID**
Print Agent's Name	**Agent's Phone**	
Agent's Email		

Send us your Application.

TO MAKE SURE YOUR FORM IS PROCESSED AS QUICKLY AS POSSIBLE, DON'T FORGET TO:

- Sign your form.
- Send all pages of the form, even if some are blank.
- If you are working with a BCBSIL agent, please include your agent's information above.

SEND BY MAIL	Blue Cross and Blue Shield of Illinois 333 W. Pierce Rd, Suite 190, Itasca, IL 60143
SEND BY FAX	847-306-6201
QUESTIONS?	If you have any questions, please call your agent or call BCBSIL toll-free at 877-329-5171.

Please include all necessary materials when submitting this Application.

If legal guardian, please enclose signed court decree.
Call 877-329-5171 or visit **coverageplusIL.com** for questions about membership or payments.