

Employee Medical Insurance Benefits Application



BlueCross BlueShield
of Illinois



Homewood-Flossmoor
Community High School District 233

Employee Information

Reason for Enrollment:

☐ New Hire ☐ Open Enrollment ☐ Special Enrollment (Qualifying Event Reason: _____)

☐ Termination

Effective Date _____

Name (Last) _____ (First) _____ (MI) _____

_____ Mailing Address _____ Apt# _____

_____ City _____ State _____

_____ Zip _____ Home (or Cell) Number _____ Email _____

_____ Social Security Number _____

Date of Birth _____ ☐ Male

☐ Female Marital Status ☐ Married ☐ Single ☐ Civil Union ☐ Domestic Partner

Date of Hire _____ Hours/Week _____ Location _____

Job Title/Occupation _____

Medical Coverage — BlueCross BlueShield of IL

Effective date of hire (Unless Qualifying Event or Open Enrollment)

Employee:

- ☐ PPO
☐ HMO (HMO Illinois Network)
☐ Waive*

Spouse:

- ☐ Elect ☐ Waive

Child(ren):

- ☐ Elect ☐ Waive

*I am waiving group medical coverage for the following reason(s): (check all that apply)

- ☐ Spouse Employer's Plan ☐ Cobra/State Continuation
☐ Individual Coverage (Non-Group Plan) ☐ Medicare or other Government Program
☐ Other (Please Explain): _____

For employee contribution amounts, please reference the document sent under separate cover.

Be sure to sign and date page 2 of this form.

Dependent Enrollment Information

SPOUSE: Name (Last) _____ (First) _____ (MI) _____
☐ Male
Social Security Number _____ Date of Birth _____ ☐ Female

Dependent: Name (Last) _____ (First) _____ (MI) _____
☐ Male
Social Security Number _____ Date of Birth _____ ☐ Female
Relationship: _____

Dependent: Name (Last) _____ (First) _____ (MI) _____
☐ Male
Social Security Number _____ Date of Birth _____ ☐ Female
Relationship: _____

Dependent: Name (Last) _____ (First) _____ (MI) _____
☐ Male
Social Security Number _____ Date of Birth _____ ☐ Female
Relationship: _____

Dependent: Name (Last) _____ (First) _____ (MI) _____
☐ Male
Social Security Number _____ Date of Birth _____ ☐ Female
Relationship: _____

Dependent: Name (Last) _____ (First) _____ (MI) _____
☐ Male
Social Security Number _____ Date of Birth _____ ☐ Female
Relationship: _____

Signature

I declare that the information I have completed on this enrollment form is complete and true. I understand an agent or broker cannot guarantee coverage, revise rates, benefits or provisions without written approval from Blue Cross/Blue Shield of IL.

A copy of this form will be as valid as the original.

Employee Signature _____ Date Signed _____