BlueCross BlueShield of Illinois

2023 Benefit Enrollment Forms
w/ Completion Instructions

This is for the health insurance - they must complete even if waiving coverage

Group Enrollment Application/Change Form

If declining coverage they complete sections 2, 8 & 9

All new hires & status changes hired w/ 30+ hours/week

Qualifying Events
4 must have documentation
of event

→ Effective 1st of the next month

Please read the instructions on the inside thoroughly before completing this enrollment application/change form.

ENROLLMENT APPLICATION/CHANGE FORM INSTRUCTIONS

PLEASE READ THOROUGHLY BEFORE COMPLETING ENROLLMENT APPLICATION/CHANGE FORM. **USE A BLACK OR BLUE BALLPOINT PEN ONLY. PRINT NEATLY. DO NOT ABBREVIATE.**

SECTION 1 ENROLLMENT EVENTS	Check all the boxes that apply to indicate if you are a new enrollee or if you are requesting a change to your coverage. Indicate the event and date, if applicable. Complete the additional sections that correspond to your selection. **New Enrollee:** Complete all sections where applicable. **Add Dependent:** Complete all sections where applicable. • If you are applying for coverage for a disabled dependent over the age limit of your employer's plan, please provide the additional information requested in Section 5. Additional documentation may be required as addressed in that section. • If your employer offers coverage for children and your children are eligible, your children are eligible for health and/or dental coverage up to the dependent limiting age and may not be denied coverage due to marital, student or employment status before age 26 (check with your employer for additional details regarding eligibility requirements). In addition, eligible military personnel may not be denied coverage before age 30 under Illinois law. If you are adding an eligible military personnel dependent who is over the age limit of the employer's plan, completion of a Defense Department Form (DD 214) is required in addition to this application. **Open Enrollment:** The period of time offered on a regular basis during which you can elect to enroll in a specific group health insurance plan or make changes to your current membership. **Special Enrollment Event:** If you qualify, special enrollment is any change to your current membership such as marriage*, divorce**, adoption, suit for adoption or placement for adoption, leave/layoff, moving out of the service area, etc. This change may occur outside of open enrollment. **Effective Date of Benefits:** Field is mandatory and should reflect your requested date. **Completion of Other Eligibility Requirements:** Check this box only if your employer has eligibility requirements that you have met/completed prior to enrollment, such as measurement period or orientation period. **Cancel Enrollee/Cancel Dependent/Cancel Coverage:** Complete Sections 1, 2, 4 (skip Section 4 if declining coverage), 8 and 9. In Section 4 include name, social security number and date of birth of individual(s) canceling.
SECTION 2 YOUR INFORMATION	Complete this section with details about yourself even if you are declining coverage.
SECTION 3 YOUR COVERAGE	Complete all portions related to the coverages for which you are applying. Please list the seven character plan ID for your selected benefit design (example: S533PPO) in the plan # field. If you are unsure of your group size or do not know your plan ID, please ask for guidance from your employer. If you are enrolling for life or disability insurance enter the information requested. When listing the beneficiary, provide both the first and last name and the relationship to you. List all beneficiaries that apply.
SECTION 4 COVERAGE OPTIONS	Complete all areas that apply to you and each dependent. For HMO Plans Only: • Those applying for HMO coverage are required to select a primary care physician/practitioner (PCP) for each covered individual. List the name of the physician/practitioner and the provider number from the provider directory or Provider Finder® at bcbsil.com. Be sure to check the appropriate box for a new patient. • If you selected HMO coverage, you must select a medical group/individual practice associations (IPAs) and a primary care physician (PCP) for each person to be covered. You must also select a PCP within the selected medical group/IPA for each person to be covered. You may choose a different medical group/IPA for each person. Care received from a woman's principal health care provider (WPHCP) may be eligible for coverage without referrals from your PCP. However, your PCP and your WPHCP must be affiliated with or employed by your medical group/IPA in order for each person to be eligible for coverage. Until we receive your selected medical group/IPA, you may not be eligible and your claims may be denied. Be sure to enter the medical group/IPA number, name, PCP number and name. • If you are adding an eligible military personnel dependent who is over the age limit of your employer's plan, completion of a Defense Department Form 214 (DD 214) is required in addition to this application. Change Primary Care Physician/Practitioner: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2, 3, 4 and 9. In Section 4, please include enrollee's or dependent's name, social security number, date of birth, name and number of the new PCP and the name and number of the new IPA. Change Address/Name: Complete Section 1 and check the "Other Change(s)" box; then, complete Sections 2 and 9.
SECTION 5 DISABLED DEPENDENT	A disabled dependent must be medically certified as disabled and dependent upon you or your spouse***/domestic partner in order to be considered for coverage if dependent coverage is part of your employer's plan. The disabled dependent is required to be covered prior to age 26 to be eligible for coverage over the dependent child age limit of your employer's plan. A Disabled Dependent Authorization and Disabled Dependent Physician Certification document must be completed and submitted with this enrollment application, if applicable.
SECTION 6 OTHER COVERAGE	Complete this section if you or any dependent have other group or individual health and/or dental coverage (if applicable) that will not be canceled when the coverage under this application becomes effective.
SECTION 7 MEDICARE COVERAGE	Complete this section if you or any of your dependents are covered by Medicare. Enter the start and end dates for the coverage that applies. Your Medicare HIC number must be listed (it can be found on your Medicare ID card). Check the reason for your Medicare coverage.
SECTION 8 DECLINATION OF COVERAGE	Complete this section if you are declining health coverage for yourself and your dependents. Anyone declining coverage for any reason should complete Section 8, not just those declining because of other coverage. **IMPORTANT NOTICE:** If you are declining enrollment for yourself or your dependents (including your spouse) because of other health care coverage, you may, in the future, be able to enroll yourself or your dependents in the plan if you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of a marriage, party to a civil union, birth, adoption, becoming a party in a suit for adoption, or placement of a foster child in your home, you may be able to enroll yourself and your dependents if you request enrollment within 31 days after the marriage, birth, adoption, suit for adoption or placement for adoption, or placement of an eligible foster child in your home.
SECTION 9 COVERAGE CONDITIONS	SIGN YOUR NAME AND DATE THE ENROLLMENT APPLICATION IF YOU AGREE TO THE CONDITIONS SET FORTH IN THIS SECTION. YOUR ENROLLMENT APPLICATION SHOULD BE SUBMITTED TO YOUR EMPLOYER'S ENROLLMENT DEPARTMENT, WHICH WILL THEN SUBMIT YOUR FORM TO BCBSIL.

AS USED ON THE APPLICATION (UNLESS INDICATED OTHERWISE): THESE TERMS MAY BE USED IN A DIFFERENT WAY IN OTHER DOCUMENTS.
* THE TERM "MARRIAGE" INCLUDES LEGAL MARRIAGE AND THE ESTABLISHMENT OF A CIVIL UNION OR DOMESTIC PARTNERSHIP (COVERAGE SUBJECT TO YOUR EMPLOYER'S PLAN).
** THE TERM "DIVORCE" INCLUDES LEGAL DIVORCE AND THE COMPARABLE TERMINATION OF A CIVIL UNION OR DOMESTIC PARTNERSHIP (COVERAGE SUBJECT TO YOUR EMPLOYER'S PLAN).
*** THE TERM "SPOUSE" INCLUDES A LEGAL SPOUSE AND A PARTY TO A CIVIL UNION OR DOMESTIC PARTNERSHIP (COVERAGE SUBJECT TO YOUR EMPLOYER'S PLAN).

CHANGES IN STATE OR FEDERAL LAW OR REGULATIONS, OR INTERPRETATIONS THEREOF, MAY CHANGE THE TERMS AND CONDITIONS OF COVERAGE.

IF YOU ARE A CURRENT MEMBER AND HAVE QUESTIONS, YOU MAY CALL THE CUSTOMER SERVICE NUMBER ON THE BACK OF YOUR MEMBER ID CARD.

If declining complete section 2, 8 & 9

GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY

SECTION 1 — ENROLLMENT EVENTS

PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

☐ NEW ENROLLEE ☐ ADD DEPENDENT ☐ OPEN ENROLLMENT ☐ OTHER CHANGES

ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT? ☐ NO ☐ YES, EVENT DATE:

EVENT: ☐ NEW HIRE ☐ MARRIAGE* ☐ BIRTH
☐ ADOPTION, PLACEMENT FOR ADOPTION OR SUIT FOR ADOPTION (PROVIDE LEGAL DOCUMENTS)
☐ COURT ORDER (PROVIDE COURT ORDER OR DECREE)
☐ LOSS OF OTHER COVERAGE
☐ OTHER (EXPLAIN):

EFFECTIVE DATE OF BENEFITS: ☐ COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS

☐ CANCEL ENROLLEE ☐ CANCEL DEPENDENT

CANCEL COVERAGE: ☐ HEALTH ☐ DENTAL
☐ TERM LIFE ☐ DEPENDENT LIFE
☐ SHORT-TERM DISABILITY ☐ LONG-TERM DISABILITY

LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW

EVENT: ☐ DIVORCE** ☐ DEATH
☐ TERMINATED EMPLOYMENT ☐ OTHER

INDICATE EVENT DATE:

SECTION 2 — PLEASE TELL US ABOUT YOURSELF

COMPLETE EVEN IF DECLINING COVERAGE

LAST NAME	FIRST NAME	MI (OPT)	SUFFIX	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #

MAILING ADDRESS - STREET - APT #	CITY	STATE	ZIP CODE

EMAIL ADDRESS	☐ MALE ☐ FEMALE	HOME/CELL PHONE #

NAME OF EMPLOYER	JOB TITLE	BUSINESS PHONE #	EMPLOYMENT DATE (MM/DD/YYYY)	ON AVERAGE, HOW MANY HOURS A WEEK DO YOU WORK? (REQUIRED)

ELIGIBILITY STATUS: ☐ ACTIVE EMPLOYEE ☐ RETIRED EMPLOYEE - DATE OF RETIREMENT: ☐ COBRA COVERAGE START DATE PROJECTED END DATE

☐ ILLINOIS CONTINUATION (INSURED PLANS ONLY) START DATE PROJECTED END DATE

SECTION 3 — SELECT YOUR COVERAGE

PLEASE CHECK ALL THAT APPLY

SMALL GROUP PLANS (1-50 EMPLOYEES)

AFFORDABLE CARE ACT PLANS

☐ PPO ☐ OTHER
☐ BLUE CHOICE PREFERRED PPO℠
☐ BLUE OPTIONS℠
☐ BLUE PRECISION HMO℠
☐ BLUECARE DIRECT℠
PLAN # (REQUIRED)

GRANDFATHERED AND GRANDMOTHERED/TRANSITIONAL PLANS

☐ BLUE ADVANTAGE ENTREPRENEUR PPO℠
☐ BLUE CHOICE SELECT PPO℠
☐ BLUE EDGE SELECT HSA℠
☐ BLUE EDGE HSA℠
☐ BLUE EDGE HCA DIRECT℠
☐ PPO VALUE CHOICE
☐ BLUE ADVANTAGE HMO℠
☐ BLUE ADVANTAGE HMO VALUE CHOICE℠
☐ COMMUNITY PARTICIPATION ORGANIZATION (CPO)
☐ CPO VALUE CHOICE
☐ OTHER
PLAN # (REQUIRED)

MID-MARKET AND LARGE GROUP STANDARD PLANS (51+ EMPLOYEES)

MID-MARKET & LARGE-GROUP STANDARD PLANS 51+

☐ PPO
☐ BLUE ADVANTAGE HMO℠
☐ BLUE ADVANTAGE HMO VALUE CHOICE℠
☐ BLUE CHOICE OPTIONS℠
☐ BLUE CHOICE SELECT PPO℠
☐ BLUE EDGE HSA℠
☐ BLUE EDGE SELECT HSA℠
☐ PLAN # (REQUIRED)
☐ OTHER

PREVIOUS BCBSIL OR HMO MEMBERSHIP

GROUP #:
SECTION #:
IDENTIFICATION #:

LARGE GROUP CUSTOM PLANS (151+ EMPLOYEES)

☐ TRADITIONAL
☐ PPO
☐ CPO
☐ CPO VALUE CHOICE
☐ HMO ILLINOIS®
☐ HMO ILLINOIS® W/HCA
☐ BLUE ADVANTAGE HMO℠
☐ BLUE ADVANTAGE HMO℠ W/HCA
☐ BLUE CHOICE OPTIONS℠
☐ BLUE CHOICE SELECT PPO℠
☐ BLUE EDGE HCA℠
☐ BLUE EDGE HSA℠
☐ BLUE EDGE HCA DIRECT℠
☐ BLUE EDGE SELECT HCA℠
☐ BLUE EDGE SELECT HSA℠
☐ BLUE EDGE SELECT HCA DIRECT℠
☐ VISION
☐ HEARING
☐ MEDICARE SUPPLEMENT
☐ OTHER

DENTAL

☐ BLUECARE DENTAL PPO℠ ☐ BLUECARE DENTAL HMO℠
☐ DENTAL GROUP #
(IF DIFFERENT THAN MEDICAL GROUP POLICY #)

☐ EMPLOYEE AND PARTY TO A CIVIL UNION OR DOMESTIC PARTNER
☐ MALE ☐ FEMALE

☐ INDIVIDUAL/EMPLOYEE ☐ EMPLOYEE/SPOUSE
☐ EMPLOYEE/CHILDREN ☐ FAMILY

PRIMARY LANGUAGE

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) AND DISABILITY INSURANCE

☐ I AM NOT APPLYING FOR GROUP TERM LIFE, AD&D OR DISABILITY INSURANCE COVERAGE

EMPLOYEE OCCUPATION/JOB TITLE: WAGE RATE $ PER ☐ HOUR ☐ WEEK ☐ MONTH ☐ YEAR

GROUP BASIC TERM LIFE AND AD&D	☐ I DO NOT APPLY	☐ I DO APPLY	AMOUNT $	
GROUP DEPENDENTS' LIFE	☐ I DO NOT APPLY	☐ I DO APPLY		
GROUP SUPPLEMENTAL LIFE	☐ I DO NOT APPLY	☐ I DO APPLY	EMPLOYEE ELECTION: $	SPOUSE ELECTION: $ CHILD ELECTION: $
SHORT-TERM DISABILITY	☐ I DO NOT APPLY	☐ I DO APPLY	LONG-TERM DISABILITY	☐ I DO NOT APPLY ☐ I DO APPLY

	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
PRIMARY BENEFICIARY						
CONTINGENT BENEFICIARY						

LAST NAME	SOC. SEC. #	GROUP #

SECTION 4 — COVERAGE OPTIONS

PLEASE COMPLETE ALL AREAS THAT APPLY
(IF YOU ARE ADDING AN ELIGIBLE MILITARY PERSONNEL DEPENDENT WHO IS OVER THE AGE LIMIT OF YOUR EMPLOYER'S PLAN, COMPLETION OF A DEFENSE DEPARTMENT FORM 214 (DD 214) IS REQUIRED IN ADDITION TO THIS APPLICATION.)

All people on the plan

EMPLOYEE/ENROLLEE'S NAME | PCP NAME | PCP # | IPA NAME | IPA #

WPHCP NAME | WPHCP # | NEW PATIENT? ☐ YES ☐ NO | HMO OB/GYN NAME (OPTIONAL) | HMO OB/GYN #

DEPENDENT'S NAME ☐ HUSBAND ☐ WIFE ☐ DOMESTIC PARTNER ☐ PARTY TO A CIVIL UNION | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

IPA NAME | IPA # | WPHCP NAME | WPHCP # | HMO OB/GYN NAME (OPTIONAL) | HMO OB/GYN #

DEPENDENT'S SOCIAL SECURITY # | BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE | IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO | IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY # | IPA NAME | IPA # | HMO OB/GYN NAME (OPTIONAL) | HMO OB/GYN #

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE | IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO | IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY # | IPA NAME | IPA # | HMO OB/GYN NAME (OPTIONAL) | HMO OB/GYN #

DEPENDENT'S NAME ☐ SON ☐ DAUGHTER ☐ OTHER ELIGIBLE DEPENDENT | DEPENDENT'S PCP NAME | PCP # | NEW PATIENT? ☐ YES ☐ NO

BIRTH DATE (MM/DD/YYYY) | HOME ADDRESS (IF DIFFERENT) STREET/CITY/STATE/ZIP CODE | IS THIS DEPENDENT A NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR A CHILD IN SUIT FOR ADOPTION? ☐ YES ☐ NO | IF NOT YOUR ELIGIBLE NATURAL CHILD, STEPCHILD, FOSTER CHILD, ADOPTED CHILD OR CHILD IN SUIT FOR ADOPTION, ARE YOU (OR YOUR SPOUSE) RESPONSIBLE FOR THIS DEPENDENT? ☐ YES ☐ NO

DEPENDENT'S SOCIAL SECURITY # | IPA NAME | IPA # | HMO OB/GYN NAME (OPTIONAL) | HMO OB/GYN #

SECTION 5 — DISABLED DEPENDENT

PLEASE COMPLETE IF APPLICABLE

NAME OF DISABLED DEPENDENT | NATURE OF DISABILITY

NAME OF DISABLED DEPENDENT | NATURE OF DISABILITY

IF DISABLED CHILD IS OVER THE DEPENDENT AGE LIMIT OF YOUR EMPLOYER'S PLAN, PLEASE ATTACH A COMPLETED DISABLED DEPENDENT CERTIFICATION AND THE DISABLED DEPENDENT PHYSICIAN CERTIFICATION DOCUMENT.

SECTION 6 — OTHER COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

COMPLETE THIS SECTION ONLY IF YOU OR ANY OF YOUR DEPENDENTS HAVE OTHER HEALTH AND/OR DENTAL COVERAGE THAT WILL NOT BE CANCELED WHEN THE COVERAGE UNDER THIS APPLICATION BECOMES EFFECTIVE. **LIST NAMES OF EACH INDIVIDUAL COVERED:**

GROUP COVERAGE ☐ YES ☐ NO | INDIVIDUAL COVERAGE ☐ YES ☐ NO | NAME AND ADDRESS OF OTHER INSURANCE CARRIER | EFFECTIVE DATE (MM/DD/YYYY) | TYPE OF POLICY ☐ EMPLOYEE ONLY ☐ EMPLOYEE/SPOUSE ☐ EMPLOYEE/CHILD(REN) ☐ FAMILY

NAME OF POLICYHOLDER | BIRTH DATE (MM/DD/YYYY) | ☐ MALE ☐ FEMALE | RELATIONSHIP TO APPLICANT ☐ SELF ☐ SPOUSE ☐ DEPENDENT

EMPLOYER'S NAME | EMPLOYMENT DATE (MM/DD/YYYY) | HEALTH GROUP # | HEALTH ID # | DENTAL GROUP # | DENTAL ID #

SECTION 7 — MEDICARE COVERAGE INFORMATION

PLEASE COMPLETE IF APPLICABLE

NAME OF PERSON COVERED:
MEDICARE A (HOSPITAL) EFFECTIVE DATE: END DATE:
MEDICARE B (MEDICAL) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) CARRIER:
MEDICARE HIC # (FROM MEDICARE CARD)

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

NAME OF PERSON COVERED:
MEDICARE A (HOSPITAL) EFFECTIVE DATE: END DATE:
MEDICARE B (MEDICAL) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) EFFECTIVE DATE: END DATE:
MEDICARE D (DRUG) CARRIER:
MEDICARE HIC # (FROM MEDICARE CARD)

PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: ☐ ENTITLED AGE ☐ ENTITLED DISABILITY ☐ END-STAGE RENAL DISEASE ☐ DISABILITY AND CURRENT RENAL DISEASE

LAST NAME	SOC. SEC. #	GROUP #

SECTION 8 — DECLINATION OF COVERAGE

PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE

THIS IS TO CERTIFY THE AVAILABLE COVERAGE HAS BEEN EXPLAINED TO ME. I HAVE BEEN GIVEN THE OPPORTUNITY TO APPLY FOR THE COVERAGE OFFERED TO ME AND MY ELIGIBLE DEPENDENTS AND HAVE VOLUNTARILY ELECTED TO DECLINE THE COVERAGE AS INDICATED BELOW. IF I DESIRE TO APPLY FOR COVERAGE AT A LATER DATE, I UNDERSTAND THERE MAY BE A DELAY IN THE EFFECTIVE DATE OF THE COVERAGE.

NAME		
NAME	☐ EMPLOYEE	REASON FOR DECLINING HEALTH: ☐ OTHER GROUP HEALTH COVERAGE – CARRIER: ☐ MEDICARE ☐ MEDICAID ☐ OTHER INDIVIDUAL HEALTH COVERAGE – CARRIER: ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ EMPLOYEE	REASON FOR DECLINING DENTAL: ☐ OTHER GROUP DENTAL COVERAGE ☐ MEDICAID ☐ INDIVIDUAL DENTAL COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY DENTAL INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ SPOUSE	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME	☐ DEPENDENT	REASON FOR DECLINING: ☐ OTHER GROUP HEALTH COVERAGE ☐ MEDICAID ☐ INDIVIDUAL HEALTH COVERAGE ☐ OTHER (EXPLAIN) ☐ I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE

SECTION 9 — COVERAGE CONDITIONS

- I am an employee or a retiree of the employer named in this enrollment application. I am eligible to participate in the coverage(s) afforded by my employer's plan, which is either underwritten or administered by Blue Cross and Blue Shield of Illinois or Dearborn Life Insurance Company. On behalf of myself and any dependents listed on this enrollment application, I apply for those coverage(s) for which I am eligible. I state that the information given on this enrollment application is true and correct. I understand and agree that any intentional misrepresentation of a material fact made by me will invalidate my coverage(s).
- Only those coverage(s) and amounts for which I am eligible will be available to me. I understand that if this enrollment application is accepted, the coverage(s) will become effective in accordance with the provisions of the Contract(s)/Plan(s).
- I agree that my employer acts as my agent. I authorize necessary payroll deduction by my employer, if any, to cover the cost of my coverage(s).
- I understand that my participation in the coverage(s) is subject to any future amendment. I also understand that all notices given to my employer are applicable to me.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

APPLICANT'S SIGNATURE DATE

Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Fax: 855-661-6960
Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html

BlueCross BlueShield of Illinois

If you, or someone you are helping, have questions, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 855-710-6984.

العربية Arabic	إن كان لديك أو لدى شخص تساعده أسئلة، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم فوري، اتصل على الرقم 855-710-6984.
繁體中文 Chinese	如果您, 或您正在協助的對象, 對此有疑問, 您有權利免費以您的母語獲得幫助和訊息。洽詢一位翻譯員, 請撥電話 號碼 855-710-6984。
Français French	Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 855-710-6984.
Deutsch German	Falls Sie oder jemand, dem Sie helfen, Fragen haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 855-710-6984 an.
Ελληνικά Greek	Εάν εσείς ή κάποιος που βοηθάτε έχετε ερωτήσεις, έχετε το δικαίωμα να λάβετε βοήθεια και πληροφορίες στη γλώσσα σας χωρίς χρέωση. Για να μιλήσετε σε έναν διερμηνέα, καλέστε 855-710-6984.
ગુજરાતી Gujarati	જો તમને અથવા તમે મદદ કરી રહ્યા હોય એવી કોઈ બીજી વ્યક્તિને એસ.બી.એમ. કાર્યક્રમ બાબતે પ્રશ્નો હોય, તો તમને વિના ખર્ચે, તમારી ભાષામાં મદદ અને માહિતી મેળવવાનો હક્ક છે. દુભાષિયા સાથે વાત કરવા માટે આ નંબર 855-710-6984 પર કૉલ કરો.
हिंदी Hindi	यदि आपके, या आप जिसकी सहायता कर रहे हैं उसके, प्रश्न हैं, तो आपको अपनी भाषा में निःशुल्क सहायता और जानकारी प्राप्त करने का अधिकार है। किसी अनुवादक से बात करने के लिए 855-710-6984 पर कॉल करें ।.
Italiano Italian	Se tu o qualcuno che stai alutando avete domande, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare il numero 855-710-6984.
한국어 Korean	만약 귀하 또는 귀하가 돕는 사람이 질문이 있다면 귀하는 무료로 그러한 도움과 정보를 귀하의 언어로 받을 수 있는 권리가 있습니다. 통역사가 필요하시면 855-710-6984 로 전화하십시오.
Diné Navajo	T'áá ni, éí doodago ła'da bíká anánílwo'ígíí, na'ídíłkidgo, ts'ídá bee ná ahóóti'i' t'áá níík'e níká a'doolwoł dóó bína'ídíłkidígíí bee nił h odoonih. Ata'dahalne'ígíí bich'į' hodíílnih kwe'é 855-710-6984.
Polski Polish	Jeśli Ty lub osoba, której pomagasz, macie jakiekolwiek pytania, macie prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 855-710-6984.
Русский Russian	Если у вас или человека, которому вы помогаете, возникли вопросы, у вас есть право на бесплатную помощь и информацию, предоставленную на вашем языке. Чтобы связаться с переводчиком, позвоните по телефону 855-710-6984.
Español Spanish	Si usted o alguien a quien usted está ayudando tiene preguntas, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 855-710-6984.
Tagalog Tagalog	Kung ikaw, o ang isang taong iyong tinutulungan ay may mga tanong, may karapatan kang makakuha ng tulong at impormasyon sa iyong wika nang walang bayad. Upang makipag-usap sa isang tagasalin-wika, tumawag sa 855-710-6984.
اردو Urdu	اگر آپ کو، یا کسی ایسے فرد کو جس کی آپ مدد کررہے ہیں، کوئی سوال درپیش ہے تو، آپ کو اپنی زبان میں مفت مدد اور معلومات حاصل کرنے کا حق ہے۔ مترجم سے بات کرنے کے لیے، 855-710-6984 پر کال کریں۔
Tiếng Việt Vietnamese	Nếu quý vị, hoặc người mà quý vị giúp đỡ, có câu hỏi, thì quý vị có quyền được giúp đỡ và nhận thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, gọi 855-710-6984.

Enrollment Application/Change/Cancellation Request

UnitedHealthcare®
A UnitedHealth Group Company

☐ UnitedHealthcare Insurance Company
☐ UnitedHealthcare Insurance Company of Illinois
☐ UnitedHealthcare of Illinois, Inc.
☐ UnitedHealthcare Insurance Company of the River Valley
☐ UnitedHealthcare Plan of the River Valley, Inc.

☐ **Enroll** ☐ **Address Change**
☐ **Cancel** ☐ **Name Change**
☐ **Change** **Date of Change**___/___/___

To Be Completed By Employer

ATTENTION EMPLOYER REPRESENTATIVE: To ensure accurate processing of application, 1) please review all sections and confirm the employee completed the appropriate information, 2) complete the information in this section and 3) provide your signature and today's date. If the employee is waiving coverage, do not submit the application but retain it for your records.

Company Name	Group #	Department #

Plan Variation	**Reporting Code**	**Benefit Level/Class Code, if applicable**
Medical _____ Vision _____	Medical _____ Vision _____	Life/AD&D _____ Suppl. Life _____
Dental _____ Life _____	Dental _____ Life _____	Spouse Life _____ Suppl. AD&D _____
UnitedHealthcare Overture Package _____ (A-S)		Dep. Life _____ Critical Illness _____

☐ **New Enrollment/Additions: (Check one)**
Date of Hire ___/___/___ Requested Date of Coverage ___/___/___
☐ New Hire ☐ Status Change (PT to FT)
☐ Return from Leave/Layoff
☐ Birth ☐ Marriage/Civil Union ☐ Adoption
☐ Court ordered dependent
☐ Other (describe) _____
☐ COBRA/State Continuation start date _____ stop date _____
☐ **Annual Open Enrollment** Requested Effective Date of Enrollment ___/___/___

☐ **Cancellations:** Last Date of Employment ___/___/___
Requested Effective Date of Cancellation ___/___/___
☐ Cancel all coverage
☐ Cancel all listed below – Section B
Reason: (check one)
☐ Death ☐ Employee Terminated ☐ Divorce
☐ Moved out of service area
☐ Dependent reached dependent max age
☐ Other (describe)_____

Employee Type ☐ Union ☐ Non-union | ☐ Salaried ☐ Hourly | ☐ Active ☐ Retire Date _____ ☐ COBRA/State Cont.

Signature _____ Date _____

A. Employee Information

Employer Position_____ Phone Number_____

Last Name	First Name L	MI	Social Security Number	Home Phone Work Phone

Address	Apt #	City	State	Zip Code	Email Address

Date of Birth / /	Sex ☐ M ☐ F	Physician* (First & Last Name) / Physician's ID Number	Primary Care Dentist Number*

Marital Status
☐ Single ☐ Married Spouse
☐ Divorced ☐ Civil Union Spouse
☐ Widowed ☐ Domestic Partner

Race – Check all that apply (Optional)**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino
☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify _____

*IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

**Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

Coverage provided by "UnitedHealthcare and Affiliates"
Medical coverage provided by UnitedHealthcare Insurance Company, UnitedHealthcare Insurance Company of Illinois, UnitedHealthcare of Illinois, Inc., UnitedHealthcare Insurance Company of the River Valley, or UnitedHealthcare Plan of the River Valley, Inc.
Dental coverage provided by UnitedHealthcare Insurance Company, Unimerica Insurance Company, or Dental Benefit Providers of Illinois, Inc.
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company
Vision Coverage provided by UnitedHealthcare Insurance Company or Unimerica Insurance Company

B. Family Information

List All Enrolling/Changing/Cancelling (Attach sheet if necessary)

Check appropriate box	Last Name / First Name / MI / Social Security Number	Sex	Relationship**	Birthdate	Physician*(First and Last Name) Physician's ID Number
☐ Enroll ☐ Cancel ☐ Change		M F	Spouse /Domestic Partner		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)* ** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*
☐ Enroll ☐ Cancel ☐ Change		M F	Dependent		
Race – Check all that apply (Optional)*** ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other–Please specify _____					Primary Care Dentist Number*

* IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.

** For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.

*** Data collected will be used only to help communicate with enrollees and inform them of specific programs to enhance their well-being and not for eligibility or claim payment determination.

C. Product Selection

Please check all that apply. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Life/Amount	Sup Life	Sup AD&D	STD	LTD	Dual Option Plan Selected
Employee	☐	☐	☐	☐ $_____	☐	☐	☐	☐	
Spouse /Domestic Partner	☐	☐	☐	☐					
Dependents	☐	☐	☐	☐ Salary _____ Required only if Life Plan based on salary					

Life Insurance Beneficiary's Full Name and Address

Relationship

D. Other Medical Coverage Information

This section must be completed. (Attach sheet if necessary.)

On the day this coverage begins, will you, your spouse or any of your dependents be covered under any other medical health plan or policy, including another UnitedHealthcare plan or Medicare? ☐ YES (continue completing this section) ☐ NO (skip the rest of this section)

Name of other carrier _____

Other Group Medical Coverage Information (only list those covered by other plan)	Type (B/S/F)*	Effective Date	End Date	Name and date of birth of policyholder for other coverage
Spouse Name:				
Dependent Name:				
Dependent Name:				
Dependent Name:				

*B. Enter 'B' when this dependent is covered under both you and your spouse's insurance plan (married)
S. Enter 'S' if you are the parent awarded custody of this dependent and no other individual is required to pay for this dependent's medical expenses.
F. Enter 'F' if this dependent is covered by another individual (not a member of your household) required to pay for this dependent's medical expenses.

Medicare – Employee Information: If enrolled in Medicare, please attach a copy of your Medicare ID card.

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

Medicare – Spouse/Dependent Name: _____

☐ Enrolled in Part A: Effective Date _____ ☐ Ineligible for Part A* ☐ Not Enrolled in Part A (chose not to enroll)
☐ Enrolled in Part B: Effective Date _____ ☐ Ineligible for Part B* ☐ Not Enrolled in Part B (chose not to enroll)
☐ Enrolled in Part D: Effective Date _____ ☐ Ineligible for Part D* ☐ Not Enrolled in Part D (chose not to enroll)
Reason for Medicare eligibility: ☐ Over 65 ☐ Kidney Disease ☐ Disabled ☐ Disabled but actively at work

*Only check "Ineligible" if you have received documentation from your Social Security benefits that indicate that you are not eligible for Medicare.

E. Waiver of Coverage

I decline coverage for:
☐ Myself
☐ Spouse
☐ Dependent Children
☐ Myself and all dependents

Declining coverage due to existence of other coverage:
☐ Spouse's Employer's Plan ☐ Individual Plan
☐ Covered by Medicare ☐ Medicaid
☐ COBRA from Prior Employer ☐ VA Eligibility
☐ Tri-Care
☐ I (we) have no other coverage at this time
☐ Other _____

I understand that by waiving coverage at this time, I will not be allowed to participate unless I qualify at a special enrollment period or as a late enrollee, if applicable, or at the next open enrollment period. I acknowledge that I have received the "Important Information" statement which is included with this form.

Employee Initials	Date

F. Signature

I confirm that the information I have provided on this form is complete and accurate.

I understand that the health benefit plan that I have selected provides reimbursement for certain medical costs, which are more fully described in the current Certificate of Coverage. I understand there may be instances where treatment decisions made by my physician or me or medical expenses which I have incurred may not be covered by my health benefit plan.

I understand that information collected in connection with administration of the benefit plan may be used to bring to my attention health products or services that might be valuable to me and otherwise as permitted by law. I understand that you may combine that information with other information so that it is no longer individually identifiable and use it for commercial and other purposes.

I acknowledge that I have received the "Important Information" statement which is included on the back of this form.

Date	Employee Signature for all applying and waiving	Spouse Signature (if applying for coverage)

Primary Language Spoken ☐ English ☐ Spanish ☐ Other _____

IMPORTANT INFORMATION

In order to make choices about your health care coverage and treatment, we believe that it is important for you to understand how your plan operates and how it may affect you. In an ever-changing environment, the information can never be complete and we urge you to contact us if, after enrollment, your Certificate of Coverage or other materials do not answer your questions. Further information is available at **www.myuhc.com** or at the toll-free Customer Care number located on the back of your identification card or on other plan materials.

1. We do not provide health care services or make treatment decisions. We help finance and/or administer the health benefit plan in which you are enrolled. That means:
   - We make decisions about whether the health benefit plan you chose will reimburse you for care that you may receive.
   - We do not decide what care you need or will receive. You and your provider make those decisions.
2. We may enter into arrangements where another entity carries out some of our duties, but those entities must operate consistently with our commitment to your plan.
3. We may use individually identifiable information about you to identify for you (and you alone) procedures, products, and services that you may find valuable.
4. We contract with networks of physicians and other providers. Our credentialing process confirms public information about the providers' licenses and other credentials, but does not assure the quality of the services provided.
5. Physicians and other providers in our networks are independent contractors and are not our employees or agents. We do not control nor do we have a right to control your provider's treatment or plan.
6. We may enter into agreements with your physician or other provider to share in the cost savings that our approach may generate. We encourage providers in our network to disclose the nature of those arrangements with you. If they do not, we encourage you to talk to your provider about these arrangements.
7. We encourage physicians and other providers to talk with you about care you or your provider think might be valuable.
8. We will use individually identifiable information about you as permitted by law, including in our operations and in our research. We will use anonymous data for commercial purposes including research.

Statement of affirmation and authorization to obtain and disclose information in connection with eligibility for coverage.

I (we) request the indicated group coverage for myself and, if the plan provides, for my dependents. I authorize any required premium contributions to be deducted from earnings.

I (we) authorize all providers of health services or supplies and any of their representatives to give the following to the HMO/insurance company(ies): any available information about the health history, condition, or treatment of any persons named in this request. I (we) authorize the HMO/insurance company(ies) to use this information to determine eligibility for health coverage and eligibility for benefits under an existing policy.

I (we) also authorize the HMO/insurance company(ies) to give this information to its (their) representatives or to any other organization for the reason notified above. I (we) agree that this authorization is valid for 30 months from the date below. I (we) know that I (we) have the right to ask for and to receive a copy of this authorization.

I understand that the Certificate of Coverage and other documents, notices, and communications regarding my health benefit plan may be transmitted electronically.

I (we) have not given the agent or any other persons any health information not included on the Request for Coverage. I (we) understand that the HMO/insurance company(ies) is not bound by any statements I (we) have made to any agent or to any other persons, if those statements are not written or printed on this Request for Coverage and any attachments.

Colonial Life

Winning Wheels
Open Enrollment 2022

Winning

Everyone's benefit needs are different. That's why it's important to choose the benefits that are right for your personal situation. Complete this page and bring it to your personal, 1-to-1 benefits counseling session. At the session, you'll learn how these products fit into your overall benefits package and how they can help protect what you've worked so hard to build.

- ☐ **Accident-** Helps offset unexpected medical expenses, such as emergency room fees, deductibles and co-payments that can result from fracture, dislocations, or other covered accidental injury.

- ☐ **Short Term Disability** – Helps replace a portion of your income to help make ends meet if you become disabled from a covered accident or covered sickness.
- ☐ **Critical Illness-** Supplements your major medical coverage by providing a lump-sum benefit you can use to pay the direct and indirect costs related to a covered critical illness, which can often be expensive and lengthy.
- ☐ **Medical Bridge-** Provides a lump-sum benefit for a covered hospital confinement or a covered outpatient surgery to help with co-payments and deductibles that are not covered by most major medical plans.
- ☐ **Life Insurance-** Enables you to tailor coverage for our individual needs and helps provide financial security for your family members.

Use this sheet as a reference point for your meeting with the benefits counselor.

Please scan the QR code below or call 217-408-4728 to schedule your meeting with the benefits counselor. If you have any questions, please feel to reach out to vickioffice.lynn@coloniallifesales

All meetings with the Benefits Counselor will be done via phone/internet.

https://bit.ly/3olS0WM the link to the video if you would like to watch it again.

if they want Colonial Life they contact the representative listed above

This form to decline IL savings Plan

Illinois Secure Choice
Retirement Savings Program

EMPLOYEE OPT OUT FORM

Illinois Secure Choice is a completely voluntary program. You can opt out at any time online, by phone, or by completing this form. If you do not opt out your employer will send payroll contributions to your Illinois Secure Choice account. Amounts you save in this account are always your money. Your account is in your control and goes with you from job to job in accordance with the Illinois Secure Choice Program terms. Every little bit you save now can potentially make a difference in retirement. To opt out of payroll contributions to Illinois Secure Choice for more than one employer you must submit a separate form for each employer.

Completed forms should be mailed back to Illinois Secure Choice.
Illinois Secure Choice
PO Box 56000
Boston, MA 02205-6000

Overnight Address:
Illinois Secure Choice
95 Wells Avenue, Suite 155
Newton, MA 02459

You may also opt out online or by phone.
855-650-6914
8 a.m. to 8 p.m. CT, Monday through Friday

saver.ilsecurechoice.com

1. EMPLOYEE INFORMATION *(All fields required)*

To verify your information, please provide either the last four digits of your Social Security Number/Taxpayer Identification Number, or your access code and date of birth. The access code can be found in the email or letter you received from Illinois Secure Choice.

Legal Name *(First)* *(M.I.)*

Legal Name *(Last)*

Address

City State Zip Code

Telephone Number *(In case we have a question)*

Last Four Digits of Social Security Number or Taxpayer Identification Number

Access Code

Birth Date *(mm/dd/yyyy)*

2. OPT OUT REASON

- ☐ I don't qualify for a Roth IRA due to my income
- ☐ I would prefer a Traditional IRA
- ☐ I have my own retirement plan
- ☐ I can't afford to save at this time
- ☐ I don't trust the financial markets
- ☐ I'm not satisfied with the investment options
- ☐ I'm not interested in contributing through this employer
- ☐ Other

3. EMPLOYER INFORMATION

Employer Name

4. SIGNATURE

I do not wish to participate in the Illinois Secure Choice Program at this time. I understand that I can change my mind at any time and begin participating in Illinois Secure Choice at a later date, subject to and in accordance with the terms of the Illinois Secure Choice Program. If I decide to opt back in, I can contact Illinois Secure Choice.

Signature of Employee

Date *(mm/dd/yyyy)*

To Enroll in the IL Savings Plan

Illinois Secure Choice
Retirement Savings Program

IRA ACCOUNT MAINTENANCE FORM

Complete this form to change your name, permanent and/or mailing address, phone number, email address, contribution rate, annual increase, or bank information. You may also update this information online by logging into your account at saver.ilsecurechoice.com.

If you are changing your legal name, your signature with your old name and your signature with your new name are required to be Medallion Signature Guaranteed in Section 3 by an authorized officer of a bank, broker, or other qualified financial institution. In place of a Medallion Signature Guarantee, you have the option to submit a signed letter of instruction with supporting legal documentation (i.e. marriage certificate, court order, divorce documentation) for this change.

The updates/changes on this form override all previous elections for this IRA. Contact the Client Service team if you need assistance completing this form.

Completed forms should be mailed to: Illinois Secure Choice
PO Box 56000
Boston, MA 02205-6000

Overnight Address: Illinois Secure Choice
95 Wells Avenue, Suite 155
Newton, MA 02459

855-650-6914
8 a.m. to 8 p.m. CT, Monday through Friday

saver.ilsecurechoice.com

1. IRA OWNER INFORMATION *(All fields required)*

If you are updating your information, enter the information that is currently on file in this section and the new information in Section 3.

Account Number

IRA Owner Legal Name *(First)* *(If you are changing your name, enter the name you have on file in this section.)* *(M.I.)*

IRA Owner Legal Name *(Last)*

☐☐☐–☐☐☐–☐☐☐☐

Telephone Number *(In case we have a question about your Account. If you are updating your phone number, enter the number you have on file in this section and the new number in Section 3.)*

Employer Name *(If you contribute through more than one employer and want to change your contribution rate or automatic annual increase election, you must submit a separate form for each employer.)*

2. ACCOUNT UPDATES OR CHANGES

Check the box(es) to indicate which section(s) you plan to update or change.

☐ **IRA Owner Information** – Section 3

☐ **Bank Information** – Section 4

☐ **Contribution Rate** – Section 5

☐ **Automatic Annual Increase** – Section 6

3 UPDATE IRA OWNER INFORMATION

If you are changing your name and/or contact information, provide the new information exactly as you would like it to appear on your Illinois Secure Choice IRA.

If you are changing your name, you must also provide a Medallion Signature Guarantee below or legal document(s) verifying the name change.

IRA Owner Legal Name *(First)* *(M.I.)*

IRA Owner Legal Name *(Last)*

Email Address

Physical Address *(We cannot accept a PO Box)*

City State Zip Code

Mailing Address If different from above *(This address will be used as the address of record and for all mailings)*

City State Zip Code

Telephone Number

Medallion Signature Guarantee — REQUIRED FOR NAME CHANGES TO THE ACCOUNT OWNER OF AN EXISTING ACCOUNT ONLY

- You must provide the following information as underwritten certification that the new signature is genuine.
- You can obtain a Medallion Signature Guarantee from an authorized officer of a bank, broker, or other qualified financial institution. A notary public cannot provide a Medallion Signature Guarantee, nor can you guarantee your own signature.
- **Do not sign below until you are in the presence of the authorized officer providing the signature guarantee.**

By signing here I certify that the information provided herein is true and complete in all respects.

Former Signature of Account Owner *(For name change only)*

Current Signature of Account Owner

Signature of Guarantor

Authorized Officer to Place Stamp Here

Title

Name of Institution

Date *(mm/dd/yyyy)*

4. UPDATE BANK INFORMATION

Important: *By signing this form, you agree and confirm that your ACH transaction will not involve the branches or offices of a bank or other financial services company located outside the territorial jurisdiction of the United States.*

☐ Add ☐ Delete Bank Information Indicated Below ☐ Delete All Current Bank Information and Add New Bank Information Below

Financial Organization Name

Financial Organization Routing Number

Financial Organization Account Number

ACCOUNT TYPE *(Select one)*

☐ Checking ☐ Savings

Note: *The routing number is usually located on the bottom left corner of your checks. You can also ask your financial organization for the routing number.*

☐ Add ☐ Delete Bank Information Indicated Below ☐ Delete All Current Bank Information and Add New Bank Information Below

Name

Financial Organization Routing Number

Financial Organization Account Number

ACCOUNT TYPE *(Select one)*

☐ Checking ☐ Savings

Note: *The routing number is usually located on the bottom left corner of your checks. You can also ask your financial organization for the routing number.*

5. UPDATE CONTRIBUTION RATE

If you wish to change your contribution rate, enter the percentage of your pay check you wish to contribute as a whole number. ***Note:*** *Your contributions to all of your Roth IRA are limited to $5,500 ($6,500 if 50 or older) for 2018 depending on your income. See IRS Publication 590A for more information.*

New Contribution Rate ☐☐☐ %

6. AUTOMATIC ANNUAL INCREASE

Contributions for accounts open at least 180 days will automatically increase by 1% on January 1 of each year, with the first increase scheduled for January 1, 2019.

☐ I wish to have my contribution rate automatically increased by 1% each year until it reaches 10%.

☐ I DO NOT wish to have my contribution rate automatically increased each year.

7. SIGNATURE

I certify that I am the account owner and verify the information above is accurate. I assume responsibility for any consequences that may result from these changes and I agree that Illinois Secure Choice, the custodian, or the program administrator are not responsible for any consequences that may arise from executing the changes outlined in this form.

Signature of IRA Owner

Date *(mm/dd/yyyy)*

United Healthcare **Vision Benefit Card**

Winning Wheels, Inc

Copays

Exam(s)	$10.00		
Eyeglasses	$25.00	Retinal Screening	$ 39.00
Contacts	$25.00		

Powered by UnitedHealthcare Vision Network

United Healthcare

mvuhcvision.com

Customer Service & Provider Locator: (800) 638-3120

TDD for Hearing Impaired: (877) 735-2929

To print a personalized ID card, please log on to our website and select 'Group/Plan' then select 'Print ID card' from the member benefits page.

Dental & Health cards will be mailed, there is no a card for vision so I explain that & give them this generic card for their records