Fort Dearborn Life Insurance Company

Employee Application

Blue Cross/ Blue Shield Of Illinois

1. Enrollment Information:

Employee Identification # (if known): _____ If this is your initial enrollment, leave blank

New Enrollment: ☐ Timely ☐ Special (If special, was on _____ (e.g. marriage)) ☐ Late

Open Enrollment: ☐ New Member ☐ Plan Change ☐ Add Dependents

Group and Section Number	Employee Social Security #
P/B 09614	__ __ __ / __ __ / __ __ __ __
Effective Date	**Date of Employment**
__ __ / __ __ / __ __ __ __	__ __ / __ __ / __ __ __ __

Employer Name: Nagle Hartray Danker Kagan McKay Penney Architects Ltd.

Employee Last Name	First Name	MI	E-Mail Address

Home Mailing Address - Street	Apt. #	City	State	Zip Code

Date of Birth	Business Telephone Number	Home Telephone Number	Gender
__ __ / __ __ / __ __ __ __	( )	( )	☐ Male ☐ Female

Previous Blue Cross and Blue Shield of Illinois Group # (if applicable):

Employment Status: ☒ Active Employee ☐ COBRA Continuation ☐ IL Continuation ☐ If Retiree, Retirement Date: __/__/__

COBRA/ Illinois Continuation Section

☐ COB RA: Start Date __/__/__ Projected End Date: __/__/__ | ☐ IL Continuation Privilege: Start Date __/__/__ Projected End Date: __/__/__

Previously covered with group as:

☐ 1. Employee (Termination of employment, Reduction in hours, other)
☐ 2. Spouse (Divorce from employee, Death of employee, other)
☐ 3. Dependent (Reached age limit, Married, No longer full-time student, other)
☐ 4. Spouse & Dependents (Divorce from employee, Death of employee, other

2. Coverage Applied for: Check all that apply based on the plans offered by your employer.

Health Plans*

Check one. ☐ **Employee** ☐ **Employee + Spouse** ☐ **Employee + Children)** ☐ **Family**

Check one.

☐ PPO [redacted] ☐ **BlueChoice Select**

☐ **HMO** *Select your PCP in section 4 and in section 5 when applicable*

[redacted]

[redacted]Care Dental Options*

If applying [redacted]ental, please complete.

Check One. ☐ Employee ☐ Employee + Spouse ☐ Employee + [redacted] ☐ Family

Check one. ☐ Dental [redacted] ☐ Dental [redacted]

Select your dental office in section 4 and 5 when applicable

Dental HMO Group #: _____

**actual billed premiums will be dependent upon the group contract in force*

Fort Dearborn Life (FDL) if applying for life coverage, please complete.

FDL Group #- **Class:**

Job Title:

Basic Salary (exclude bonuses) $

☐ **Hourly** ☐ **Weekly** ☐ **Semi-Monthly** ☐ **Monthly** ☐ **Annual**

Number of hours worked in a normal work week:

☐ **Term Life/ AD & D** ☐ **Voluntary Life**

☐ **Dependent Life** Employee Amount $ _____

☐ **Short Term Disability** Spouse Amount $ _____

FDL Beneficiary: If more than one beneficiary is named, interest will be equal unless otherwise indicated.

1. Last Name _____ First Name _____
   Relationship _____ Age _____ Percentage _____
2. Last Name _____ First Name _____
   Relationship _____ Age _____ Percentage _____

3. Medicare/ESRD Coverage Information If you or your dependents are covered under your employer's health plan and covered by Medicare, please complete.

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

Name: HIC #

Medicare A	Medicare B	ESRD Dialysis	Disability
Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __	Start Date: __ __/__ __/__ __

4. Employee Coverage Information — HMO - CPO — DENTAL HMO — If selected

IF HMO

If you have chosen HMO: Medical Group/IPA # __ __ __ Medical Group/IPA Name: KID # __ __ __ __ __ __ __ __ __ PCP Name:

WPHCP Medical Group/IPA # __ __ __ WPHCP Medical Group/IPA Name: WPHCP # __ __ __ __ __ __ __ __ __ WPHCP (Physician) Name*:

*Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and WPHCP must have a referral arrangement with one another.

If you have chosen CPO/CPO Value Choice: Network # CO_____ **Dental HMO Office I D #** _____

Employer Name:
Nagle Hartray Danker Kagan McKay Penney Architects Ltd.

Employee Social Security #
___-__-____

5. Family Coverage Information: Complete for your Spouse and all children to be covered.

Last Name (if different) First Name MI

Spouse: Date of Birth __/__/____ Social Security # ___-__-____

If you have chosen HMO: Medical Group/IPA # ___ Medical Group/IPA Name: PCP # ____ PCP Name:

WPHCP Medical Group/IPA # ___ WPHCP Medical Group/IPA Name: WPHCP # ____ WPHCP (Physician) Name:

Dental HMO Office ID #

Last Name (if different) First Name MI

☐ Son ☐ Daughter Date of Birth __/__/____ Social Security # ___-__-____ Full time student? ☐ Yes ☐ No

If you have chosen HMO: Medical Group/IPA # Medical Group/IPA Name: PCP # ____ PCP Name:

WPHCP Medical Group/IPA # ___ WPHCP Medical Group/IPA Name: WPHCP # ____ WPHCP (Physician) Name':

Dental HMO Office ID #

Last Name (if different) First Name MI

☐ Son ☐ Daughter Date of Birth __/__/____ Social Security # ___-__-____ Full time student? ☐ Yes ☐ No

If you have chosen HMO: Medical Group/IPA # / Medical Group/IPA Name: PCP # ____ PCP Name:

WPHCP Medical Group/IPA # ___ WPHCP Medical Group/IPA Name: WPHCP # ____ WPHCP (Physician) Name:

Dental HMO Office ID#

Last Name (if different) First Name MI

☐ Son ☐ Daughter Date of Birth __/__/____ Social Security # ___-__-____ Full time student? ☐ Yes ☐ No

If you have chosen HMO: Medical Group/IPA # ___ Medical Group/IPA Name: PCP # ____ PCP Name:

WPHCP Medical Group/IPA # WPHCP Medical Group/IPA Name: WPHCP # ____ WPHCP (Physician) Name:

Dental HMO Office ID#

'Female members may also choose a Woman's Principal Health Care Provider (WPHCP). A WPHCP may be seen for care without referrals from your PCP; however, the PCP and AVPHCP must have a referral arrangement, with one another.

6. Other Insurance Information: Complete ONLY if you or your dependents have other group coverage.

Do you or any of your family members have OTHER GROUP COVERAGE **that will not be cancelled** when this application is approved? ☐ Yes ☐ No

If yes, complete the following section. Check all that apply. This information will be used to coordinate benefits with the other insurance company.

Health coverage for: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other Policy Number ____ ☐ Single ☐ Family

Name of Insured: SSN: ___/__/____ Date of Birth: __/__/____

Employer Name: Name and Address of Insurance Company:

City State Zip Telephone #

Dental coverage for: ☐ Self ☐ Spouse ☐ Dependent Child ☐ Other Policy Number ____ ☐ Single ☐ Family

Name of Insured: SSN: __/__/____ **Date of Birth:** __/__/____

Employer Name: **Name and Address of Insurance Company:**

City **State** **Zip** **Telephone #**

7. Application for Coverage

I apply for coverage as indicated above, for which I am or may become eligible tinder the agreement with Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (providing hospital, medical, dental and health maintenance coverage) and/or Fort Dearborn Life Insurance Company (providing life and disability insurance) which are herein collectively called the Company. I have read the above statements and represent they are true and complete to the best of my knowledge. I authorize my employer/group to deduct from my pay and remit my required contribution for the cost of said coverage. This authorization is to remain in effect until the Company is notified by me in writing to the contrary. I understand that the benefits listed in the Certificate(s) will be available subject to the Terms and Conditions thereof effective as listed in the Certificate(s) of Coverage.

Authorization

I authorize my medical professional, hospital, other medical facility or medical provider to disclose to the Company Underwriting Department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the date that you receive notice of the Company decision my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of the revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

Signature of Employee to be covered: X _____ **Date Signed:** X _____

Fort Dearborn Life Insurance Company

Medical Questionnaire

BlueCross/ Blue Shield Of Illinois

Employee Social Security # ___-___-____

Group Name Nagle Hartray Danker Kagan McKay Penney Architects Ltd.	**Group and Section Number** P/B09614		**Employee ID #**	
Employee Name	☐ Male ☐ Female	D.O.B. ___/___/___	**Height**	**Weight** lbs.
Spouse Name	☐ Male ☐ Female	D.O.B. ___/___/___	**Height**	**Weight** lbs.
Dependent	☐ Male ☐ Female	D.O.B. ___/___/___		
Dependent	☐ Male ☐ Female	D.O.B. ___/___/___		
Dependent	☐ Male ☐ Female	D.O.B. ___/___/___		
Dependent	☐ Male ☐ Female	D.O.B. ___/___/___		

HEALTH QUESTIONS

For Health Coverage: To be completed and signed by the employee if the group has 2-50 employees enrolled for health coverage. Signature of spouse is required if spouse is applying for coverage. For Fort Dearborn Life Coverage: To be completed by the employee if the group has two or more eligible employees and is applying for an amount over the guarantee issue, applying for voluntary life cove rage or for any late enrollment.

Directions. Please check: ☐ *Yes or* ☐ *No.* I *If any boxes are checked "yes" (☐ Yes), circle the condition, e.g. (Stroke) and give details below.*

1. Have you or any dependents to be covered been hospitalized, advised, diagnosed, or treated bv a physician in the past 5 years for: (If box is checked yes, please circle the condition and provide details below)

A. Stroke, heart, circulatory, vascular disease or disorder, high blood pressure?	☐ Yes ☐ No
B. Cancer, Tumors, Leukemia) Lupus or any other systemic disease?	☐ Yes ☐ No
C Multiple Sclerosis, paralysis, arthritis, bone/joint/back and muscle disorders?	☐ Yes ☐ No
D. Asthma, Emphysema, respiratory and lung disorders?	☐ Yes ☐ No
E. Diabetes, pancreas, growth disorder, or endocrine disorder?	☐ Yes ☐ No
F. AIDS, tested positive for HIV, immune system disorders, blood disorders?	☐ Yes ☐ No
G. Hepatitis, liver disorder, digestive system disease or disorder, colon disorder, kidney, prostate, reproductive organs disorder, infertility?.	☐ Yes ☐ No
H. Brain/seizure disorders, mental/emotional disorders, alcohol/drug/substance abuse or dependency?	☐ Yes ☐ No
L Organ or bone marrow transplant?	☐ Yes ☐ No
2. Are you, your spouse, or any dependent to be covered currently pregnant?	☐ Yes ☐ No
3. Has any person to be covered taken any prescription medication in the past 12 months, had surgery in the past 12 months or had surgery recommended?	☐ Yes ☐ No
4. Have you used cigarettes or other tobacco products in the last 12 months?	**Employee:** ☐ Yes ☐ No
	Spouse: ☐ Yes ☐ No

If You answered YES to any of the above questions, please provide details below.

DETAILS OF MEDICAL HISTORY

Question #	Person/Who	Condition/Diagnosis	Treatment/Rx Prescribed	Treatment Date	Date of Recovery

List all medications taken currently or within the last 12 nzontlys by anyperson to be covered.

DETAILS OF MEDICATIONS

Person	Name of Medication	Dosage	Illness for which prescribed	Treatment Date	Currently taldng?
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

I authorize any medical professional, hospital, other medical facility or medical provider to disclose to tile HCSC and FDL (the Company) Underwriting Department my medical records, including information concerning advice, care or treatment for any condition, except that this authorization does not include psychotherapy notes. I understand that this authorization will enable the Company to request medical information in order to consider my application for coverage. This authorization shall expire on the (late that you receive notice of the Company's decision on my application. I understand that I may revoke this authorization at any time, but that such a revocation will have no effect on any actions taken by the Company prior to receipt of tile revocation. I understand that information disclosed pursuant to the authorization may be redisclosed and no longer protected by the federal privacy laws. I understand that I should retain a duplicate copy of this authorization for my own records. I authorize Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company and Fort Dearborn Life Insurance Company or their designee to transmit the information contained herein electronically.

X _____ X _____

Signature of Employee | Signature of Spouse | Date