Dear Associates,

Please find the attached : Blue Cross Blue Shield Health and Dental Application, and the United Health Life Insurance Application. Also you will find the Payroll Deduction Sheet.

Your Store Manager has informational insurance packets for you. Also, on the Sullivan's Foods Website under the Employee Portal you will find the Book for Health Insurance with Blue Cross Blue Shield with all the links. You can click on the links for any additional information . The Password for the Employee Portal is: sullivans!

To start with you might want to start with the ***Payroll Deduction Sheet***, as that shows the bi-weekly payroll deduction amount that will come out of your paycheck depending on what you select for coverage. Please complete that form, sign it and date it accordingly. Reminder if you want to start a Health Savings Account, you must complete the form, but nothing can be taken of your paycheck till an account is set up with one of the local banks. You will then need to get the bank account information to *Annie in Payroll.*

Blue Cross Blue Shield Application : This form is for Health and Dental. Regardless if you elect Health or Dental you need to complete SECTION 2. If you want Health – you will mark the box in the "MID MARKET SECTION". If you want Dental Insurance you will complete the "DENTAL SECTION – indicating if you want Sullivan's BLUE CARE DENTAL PPO NETWORK. You will Also indicate on the rt side of that area who you want covered.

SECTION 4 - This is where you will add any family members that you want covered on health and / or dental. You may write notes off to the side if need be.

Section 6 and Section 7 – complete these if they apply.

SECTION 8 – If you are declining coverage you must complete this section.

Section 9 – You must sign - regardless if you want insurance or are refusing it – it is a signature that indicates that you have been given the opportunity for Health and Dental Insurance.

United Health Care LIFE INSURANCE APPLICATION - Please complete Section A regardless if you want Life insurance. If you want to Decline Life you will automatically go to page 3 and Mark box or boxes in Section E and then Initial and date the Right side of the Section E. You will also sign page 4 .

If you are adding family members on for Life Insurance you will need to complete Section B. Please remember to complete Section C – for your Beneficiary for Life Insurance.

Any questions please don't hesitate to call Annie at Sullivan's Office. 815-273-4511.

J. B. Sullivan Inc Payroll Deduction Sheet – Policy Year starting January 1, 2023

Employee Name____ Store____________________.

Each year Sullivan's Foods has a renewal process and an open enrollment period which allows you to make changes to your policy.

Please circle the coverage that you selected below with the corresponding payroll deduction amount. Write in the payroll deduction amount on the corresponding line .

Health Insurance 2023 — Blue Cross Blue Shield of Illinois :

Employee Only	Employee/Spouse	Employee / Child	Family	Refused	
$70.45	$208.16	183.36	$292.89	00000000	______

Dental Insurance 2023 – Blue Cross Blue Shield of Illinois:

Employee Only	Employee / Spouse	Employee / Child	Family	Refused	
$17.00	$34.00	$39.05	$61.12	00000000	_______

Life Insurance 2023 – United Health Care :

Employee Only	Employee / Spouse	Employee / Child	Family	Refused	
.74	.95	.95	.95	00000000	________

Health Savings Account: Sullivan's Foods offers Health Savings Accounts which assists you in planning and paying for your deductible expenses with pre-tax dollars. You will need to have your Health Savings Account Information completed and the account open with the account number to your store Managee or Annie in Payroll before deduction can start. We work with the following institutions :

Triumph Bank	**Citizens State Bank**	**First State Bank**	**Union Savings Bank**
Savanna	**Stockton/ Lena**	**Princeton/ Kewanee**	**Freeport / Mt Morris**
Morrison	**Freeport**	**Mendota**	**Winnebago / Marengo**

Dollar amount you want payroll deducted for your Health Savings Account. (We cannot start deductions until all the paper work has been completed and the account is set up). ______________

Per this signed agreement, I understand that Sullivan's offers a high deductible health insurance plan for 2023 calendar year and that United Health care remains our carrier for Life insurance I agree to the bi weekly payroll deductions as listed above.

Signature____ ____________

Group Enrollment Application/Change Form

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

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association
Life and Disability insurance is underwritten by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Dearborn Life Insurance Company is an independent Blue Cross and Blue Shield licensee.
BLUE CROSS,® BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

232320.0919

Blue Cross Blue Shield medical and Dental Application

GROUP #	SECTION #	SOC. SEC. #	ACCOUNT # 189385	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 J.B. Sullivan	JOB TITLE *	BUSINESS PHONE # 815-278-4511		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

Sullivan's Plan * ☐ 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

Life Insurance is with UHC, will need to Complete their application.

☐ 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.)

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.

If declining

NAME		REASON
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 *

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

Life, Disability, Critical Illness, Accident, and Vision products are issued by Dearborn Life Insurance Company, 701 E. 22nd St. Suite 300, Lombard, IL 60148. Blue Cross and Blue Shield of Illinois is the trade name of Dearborn Life Insurance Company, an independent licensee of the Blue Cross and Blue Shield Association. BLUE CROSS®, BLUE SHIELD® and the Cross and Shield Symbols are registered service marks of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans.

Medical, Pharmacy, and Dental products are offered by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association.

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	Phone:	855-664-7270 (voicemail)
300 E. Randolph St.	TTY/TDD:	855-661-6965
35th Floor	Fax:	855-661-6960
Chicago, Illinois 60601	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	Phone:	800-368-1019
200 Independence Avenue SW	TTY/TDD:	800-537-7697
Room 509F, HHH Building 1019	Fax:	855-661-6960
Washington, DC 20201	Complaint Portal:	https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
	Complaint Forms:	http://www.hhs.gov/ocr/office/file/index.html

Enrollment Application/Change/Cancellation Request

Illinois

UnitedHealthcare

☐ Enroll
☐ Cancel
☐ Change

☐ Address Change
☐ Name Change
Date of Change

☐ 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

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
Medical ____ ~~Vision~~ ____
Dental ____ Life ____

Reporting Code
Medical ____ ~~Vision~~ ____
Dental ____ Life ____

Benefit Level/Class Code, if applicable
Life/AD&D ______ Suppl. Life ______
Spouse Life ______ Suppl. AD&D ______

☐ **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 ☐ 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 ☐ COBRA/State Cont. ☐ Retire Date ______ | #Hours worked per week ______

Signature ______ Date ______
Employer Position ______ Phone Number ______

A. Employee Information

Last Name | First Name | MI | Social Security Number

Address | Apt # | City | State | Zip Code | Home Phone

Cell Phone

Date of Birth / / | Sex ☐ M ☐ F | Marital Status ☐ Single ☐ Divorced ☐ Married ☐ Widowed | Work Phone

Language Preference, if not English ______

Email Address

Race – Check all that apply (Optional)[2]
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American
☐ Hispanic/Latino ☐ Native Hawaiian/Pacific Islander ☐ White
☐ Other–Please specify ______

Primary Physician[1]
Physician First & Last Name ______
ID# ______

Primary Dentist[1]
Dentist First & Last Name ______
ID# ______

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.
[2]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
Life, Short-Term Disability (STD), Long-Term Disability (LTD) Insurance coverage provided by UnitedHealthcare Insurance Company
Vision coverage provided by UnitedHealthcare Insurance Company

If want Life Insurance on Spouse *

B. Family Information

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

Check appropriate box	Relationship[2]	Last Name	First Name	MI	Sex	Date of Birth
☐ Enroll ☐ Cancel ☐ Change	Spouse * /Domestic Partner	*			☐M ☐F	__/__/__
		Social Security Number | | |—| | |—| | | |	Primary Physician[1] Name: ID#			
Race – Check all that apply (Optional)[3]	☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other–Please specify ____		Primary Care Dentist[1] Name: ID#			
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐M ☐F	__/__/__
		Social Security Number | | |—| | |—| | | |	Primary Physician[1] Name: ID#			
Race – Check all that apply (Optional)[3]	☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other–Please specify ____		Primary Care Dentist[1] Name: ID#			
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐M ☐F	__/__/__
		Social Security Number | | |—| | |—| | | |	Primary Physician[1] Name: ID#			
Race – Check all that apply (Optional)[3]	☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other–Please specify ____		Primary Care Dentist[1] Name: ID#			
☐ Enroll ☐ Cancel ☐ Change	Dependent				☐M ☐F	__/__/__
		Social Security Number | | |—| | |—| | | |	Primary Physician[1] Name: ID#			
Race – Check all that apply (Optional)[3]	☐American Indian/Alaska Native ☐Asian ☐Black/African-American ☐Hispanic/Latino ☐Native Hawaiian/Pacific Islander ☐White ☐Other–Please specify ____		Primary Care Dentist[1] Name: ID#			

If want Child Life $1,000. on each Child

[1]IMPORTANT: Please see employer representative as some plans require a Primary Physician (Primary Care) and/or a Primary Care Dentist (PCD) selection.
[2]For some cases, such as Qualified Medical Child Support, additional documentation may be required. Please see employer representative for more information.
[3]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 the box for each coverage in which you or your dependents are enrolling.
If your employer offers a choice of plans, indicate which plan you are selecting. Indicate the dollar amount selected for the Life and Accidental Death & Dismemberment (AD&D), Supplemental Life, Short-Term Disability (STD), and Long-Term Disability (LTD) plans. Benefit offerings are dependent upon employer selection.

Person	Medical	Dental	Vision	Basic Life/AD&D	Supp Life/AD&D	Voluntary AD&D
Employee (25K)	☐	☐	☐	☐$	☐$	☐$
Spouse/Domestic Partner (5K)	☐	☐	☐	☐$	☐$	☐$
Dependent (1K)	☐	☐	☐	☐$	☐$	☐$

Person	STD	LTD	STD Buy Up	LTD Buy Up	Salary $ ____ Required only if Life, STD, or LTD based on salary
Employee	☐	☐	☐	☐	

Life Insurance Beneficiary Full Name and Address (if applying for Life Insurance with UnitedHealthcare)		Relationship
* Primary		
* Secondary		

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Please Complete Above Beneficiary

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

*Note this is if you decline

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

↑ Please initial and Date if waiving Life

F. Signature

Your enrollment in the plan is expressly conditioned upon your acceptance of all terms and conditions contained in this enrollment application. If you do not agree to the following terms and conditions, you may not complete your enrollment.

TERMS AND CONDITIONS

As a condition of my and/or my dependents' participation in the plan, and in consideration for the privileges that come from participation in the plan, I hereby agree for myself and/or for my dependents as follows:

I recognize and understand that the plan contracts with physicians and other providers that make up the plan network. I recognize that all physicians and other providers that participate in the plan network are subject to credentialing under applicable State regulations and pursuant to the plan's network credentialing process. I understand that such credentialing includes a review of provider education, training and licensure. However, by participating in the plan I hereby acknowledge and accept that the plan is not a provider of medical services, and I am aware that obtaining or not obtaining medical care involves significant risks such as serious injury and even death. I acknowledge that the credentialing of physicians and other providers does not in any way reduce this risk. I agree to assume all risks and responsibility for, and hold the plan harmless from, any and all claims for damages, including personal injury or death, medical expenses, disability, lost wages, and loss of earning capacity which may be incurred or associated with medical treatment obtained through a participating physician or other provider. I recognize that all physicians and other providers that participate in the plan network are independent contractors and not the plan's employees or agents and are solely responsible for any malpractice, adverse outcomes, or any other claims arising from medical treatment rendered to me and my dependents. I HEREBY AGREE THAT THE PLAN IS NOT RESPONSIBLE NOR LIABLE FOR ANY ADVICE, COURSE OF TREATMENT, DIAGNOSIS OR ANY OTHER INFORMATION, SERVICES OR PRODUCTS THAT I OR MY DEPENDENTS OBTAIN THROUGH A PARTICIPATING NETWORK PHYSICIAN OR OTHER PROVIDER.

(continued on next page)

F. Signature (Continued)

I recognize and understand that the plan does not recommend, endorse or make any representation about the appropriateness or suitability of any specific tests, products, procedures, treatments, services, or opinions. I recognize that the plan, plan documents, and any health and wellness information provided by the plan, are not intended or implied to be a substitute for professional medical advice, diagnosis or treatment. I agree to confirm any medical information obtained from or through the plan with other sources, and will review all information regarding any medical condition or treatment with my physician. I HEREBY AGREE TO NEVER DISREGARD PROFESSIONAL MEDICAL ADVICE OR DELAY SEEKING MEDICAL TREATMENT BECAUSE OF SOMETHING I HAVE READ OR ACCESSED THROUGH THE PLAN.

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.

Sign for Life coverage *

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

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

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.