

Illinois Health Agents, Inc.

Application Instructions for Blue Cross and Blue Shield of Illinois

1. Print all pages of the application, including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Illinois Health Agents, Inc. for review along with the completed application. If you do not have access to a fax machine, send the completed application to Illinois Health Agents, Inc. along with the required premium payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must complete the authorization form and attach a voided check to the area provided.

Don't forget to **enclose a check for the required payment made payable to Blue Cross and Blue Shield of Illinois**. If you are paying by Monthly Bank Draft, please submit a check for 1 month's premium. If you are paying by Two-Month Direct Bill, please submit a check for 2 month's premium.

Mail completed applications to:

Illinois Health Agents, Inc.

Attn: New Enrollment

75 Forest Ave.

Glen Ellyn, IL 60137

Illinois Health Agents, Inc. will review your application for completeness and accuracy before they submit it to Blue Cross and Blue Shield of Illinois for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 630-930-9364 or e-mail us at ryan@ilhealthagents.com.

Illinois Health Agents, Inc.

FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

Illinois Health Agents, Inc.

FAX# 847-220-9280

Dear Illinois Health Agents, Inc.,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____
after you have reviewed my application for completeness and accuracy.

I will contact Illinois Health Agents, Inc. at 630-930-9364 to verify receipt of my application.

****I understand that Illinois Health Agents, Inc. will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to Illinois Health Agents, Inc. :

Illinois Health Agents, Inc.

Attn: New Enrollment

75 Forest Ave.

Glen Ellyn, IL 60137

I will send the original, signed application and premium payment, as soon as I have been contacted by Illinois Health Agents, Inc. with confirmation that my application has been received by fax and reviewed for completeness.

APPLICATION FOR INDIVIDUAL COVERAGE



BlueCross BlueShield of Illinois

HOME OFFICE USE ONLY

To help us process your application promptly, please remember to:

- Print all answers in **blue or black ink**. Pencil will not be accepted.
- Make sure you personally sign the application as the Primary Applicant. If your spouse or any dependent(s) age 18 or over is also applying for coverage, have him/her personally sign the appropriate signature space.
- If it is necessary to correct any errors, simply cross off what is incorrect and write your initials next to the correct information. Please do not use correction fluid or tape.

XXXXXXXXXXXXXXXXXX XXXXXXXXXXXXXXXXXX	

Please note to be eligible for an HSA plan you must be 18 years or older. If choosing an HSA plan, please be reminded that Health Savings Accounts (HSA) have tax and legal ramifications. Health Care Service Corporation, d/b/a Blue Cross and Blue Shield of Illinois, does not provide legal advice, and nothing herein should be construed as legal or tax advice. Please consult your tax advisor for information regarding the tax consequences of specific health insurance plans and products.

Select all that apply: New Policy Add Spouse and/or Dependent(s) Upgrade (increase of benefits)

SECTION A — PERSON(S) APPLYING FOR COVERAGE (please print)

In addition to having a permanent residence in Illinois, all persons applying for coverage who are not U.S. citizens must have resided in the U.S. for at least six months AND have had a complete physical by a physician in the U.S. within the past two years.

PRIMARY APPLICANT INFORMATION

First Name, Middle Initial, Last Name		Social Security # - -	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age	Date of Birth (Mo./Day/Yr.) / /	Height (ft., in.)	Weight (lbs.)
Residential Street Address (no P.O. Boxes)				City / State / ZIP			
Home Phone # ()	Work Phone # ()	Cell Phone # ()	Fax # ()	Spouse's Business Phone # (if applying) ()			
Email Address		Occupation/Duties (optional)			Best place and time to call (if necessary) <input type="checkbox"/> Home <input type="checkbox"/> Business <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening		

SPOUSE and UNMARRIED DEPENDENT CHILDREN YOU WISH TO COVER (Dependent children must be under age 26, or under age 30 if a military veteran.)

NAME: First	M.I.	Last	RELATION	SEX	HEIGHT (ft., in.)	WEIGHT (lbs.)	DATE OF BIRTH (Mo./Day/Yr.)	SOCIAL SECURITY NUMBER
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -
			<input type="checkbox"/> Spouse <input type="checkbox"/> Child	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	- -

SECTION B — COVERAGE APPLIED FOR (please choose only one health plan with one deductible and one level of coverage)

- | | |
|--|---|
| <input type="checkbox"/> SelectBlue®
Deductible: <input type="checkbox"/> \$0 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500
<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80% | <input type="checkbox"/> BlueEdgeSM Individual HSA
Deductible:
<input type="checkbox"/> \$1,150 for a single applicant or \$2,300 for a family*
<input type="checkbox"/> \$1,750 for a single applicant or \$3,500 for a family
<input type="checkbox"/> \$2,600 for a single applicant or \$5,200 for a family
<input type="checkbox"/> \$3,500 for a single applicant or \$7,000 for a family
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80%
* The deductible amount will be adjusted automatically if the amount is lower than the amount required by law. |
| <input type="checkbox"/> SelectBlue AdvantageSM
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 80% | <input type="checkbox"/> BlueEdgeSM Individual HSA 5000
Deductible: \$5,000 for a single applicant or \$10,000 for a family
Level of Coverage: <input type="checkbox"/> 100% |
| <input type="checkbox"/> BlueChoiceSM Select
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 80% | <input type="checkbox"/> Traditional BlueSM
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80% |
| <input type="checkbox"/> BlueValueSM
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 100% <input type="checkbox"/> 80% | <input type="checkbox"/> BasicBlue®
Deductible: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500
Level of Coverage: <input type="checkbox"/> 80%
Maternity Option Not Available |
| <input type="checkbox"/> BlueValue AdvantageSM
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 80% | |
| <input type="checkbox"/> BlueChoiceSM Value
Deductible: <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
<input type="checkbox"/> \$1,750 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000
Level of Coverage: <input type="checkbox"/> 80% | |

OPTIONAL COVERAGE:

- | | |
|--|--|
| <input type="checkbox"/> Include Maternity Coverage? (NOT available on BasicBlue)
You MUST choose a health plan in order to apply for maternity coverage. | <input type="checkbox"/> BlueCare® Dental PPO
You MUST choose a health plan in order to apply for dental. |
|--|--|

SECTION C – BILLING INFORMATION

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

REQUESTED EFFECTIVE DATE (Mo./Day/Yr.) _____ / _____ / _____ (Note: Day cannot be 29th, 30th or 31st.)

PREMIUM AMOUNT ENCLOSED \$ _____

- PREMIUM MODE:** Monthly Bank Draft (Submit Authorization form with application, along with a copy of voided check or deposit slip)
 Two-Month Direct Bill
 List Bill (submit a "Personal Health Insurance Certificate for Employees" form with the application)

Billing Name and Address (If different than applicant name and residential address. If an address is entered in this section, only the billing will be sent to this address; all other correspondence will be sent to the address in Section A, unless you request otherwise.)

First Name, Middle Initial, Last Name	
Billing Street Address (P.O. Boxes acceptable)	City / State / ZIP
Name of Employer (if requesting List Bill only)	

SECTION D – HEALTH HISTORY / MEDICAL QUESTIONS

All health history/medical questions must be completed for all individuals (including adults and children) applying for coverage.

If you answer "Yes" to ANY questions in Section D - Health History / Medical Questions, please give complete details in Section E – Details of Health History. Please note the timeframe reference for each question.

1. Within the last 10 years has any person applying for coverage been advised, counseled, tested, diagnosed, treated, prescribed medication, hospitalized or recommended for treatment for the following: Please answer Yes or No. If any boxes are checked "Yes" (Yes), also circle the condition, e.g. migraines, and give details in Section E – Details of Health History.

- A. Migraines; headaches; epilepsy or seizure disorder; head injury or concussion; any neurological disorder; neuropathy; paralysis; multiple sclerosis; or any other central or peripheral nervous system disorder? Yes No
- B. Attention deficit disorder; anxiety, depression or chemical imbalance; insomnia; bipolar disorder; mental retardation; any behavioral, emotional, or mental disorder; eating disorder; pervasive development disorder or autism spectrum disorder; marital or any form of counseling or therapy? Yes No
- C. Chest pain; palpitations; heart murmur; mitral valve prolapse; arrhythmia or irregular heartbeat; heart attack, stroke or TIA, any other heart or circulatory disorder or condition, or hypertension/high blood pressure (HBP)? Yes No
If "Yes" to HBP, provide 3 readings and their dates w/in the last year
_____ and _____ and _____
- D. Elevated cholesterol, triglycerides or other lipids (including if controlled by diet or exercise)? Yes No
If "Yes", provide the date and results of most recent testing:
Date: _____ Total Chol: _____ HDL: _____ Triglycerides: _____
- E. Varicose veins; spider veins; varicosities; anemia; blood clot or any other blood disorder? Yes No
- F. Asthma; allergies; sinusitis; bronchitis; pneumonia; tuberculosis; apnea; chronic obstructive pulmonary disease (COPD); emphysema; breathing difficulty, or any other lung or respiratory disease, disorder or condition? Yes No
- G. Acid reflux; gastroesophageal reflux (GERD); Barrett's or any other disorder of the esophagus; irritable bowel syndrome (IBS); colitis; diverticular disease; chronic diarrhea or intestinal problem; ulcer; hernia; hemorrhoids or rectal disorder; or any other digestive disorder or condition? Yes No
If "Yes" to hernia, indicate type: _____
- H. Any disease or disorder of the gallbladder, pancreas or liver; elevated liver function tests; cirrhosis; hepatitis? Yes No
If "Yes" to hepatitis, indicate type: _____
- I. Cancer; tumor; growth; cyst; polyp; enlarged lymph nodes; leukemia? Yes No
If "Yes", indicate diagnosis and location _____
- J. Acne; keratosis; psoriasis; basal cell carcinoma; malignant melanoma; lesions of the skin or mouth; hemangiomas; or any other skin disorder? Yes No
- K. Kidney stones; urinary reflux; urinary incontinence or any infection or disorder of the urinary tract, bladder or kidney? Yes No
- L. Breast cyst or nodule; gynecomastia; fibrocystic breast disease; breast implants, or any other disease or disorder of the breast? Yes No
- M. Back or spinal disorder; herniated, bulged, protruded, ruptured or slipped disc; degenerative disc disorder; or any other injury to, disease or disorder of the back or spine? Yes No
- N. Arthritis (e.g. osteo, rheumatoid, psoriatic, etc.); gout; bursitis; carpal tunnel syndrome; pinched nerve; bunion; temporomandibular joint syndrome (TMJ); any injury to, disease or disorder of the knees, shoulders, jaw, bones, muscles or joints; joint replacement; or received chiropractic adjustments or manipulation therapy? Yes No
- O. Hypothyroidism; hyperthyroidism, Graves' disease; goiter; nodule or any other thyroid disorder; diabetes; elevated blood sugar; glucose intolerance; insulin resistance or any other metabolic, endocrine, pituitary or adrenal disorder; lupus; chronic fatigue syndrome; connective tissue or autoimmune disorder? Yes No

Applicant Name _____

P. Cataracts; glaucoma; hearing loss; deviated nasal septum; or any eye, ear, nose, speech, or throat disorder? .. Yes No

Q. Been medically treated for or diagnosed by a physician or a member of the medical profession as having AIDS, ARC, diseases associated with AIDS or other immune disorders, or ever tested positive by a physician or a member of the medical profession for antibodies to the Human Immunodeficiency Virus (HIV)?..... Yes No

R. For all MALE persons applying (adults and children)
Prostate disorder; elevated prostate specific antigen (PSA); sexually transmitted disease; genital warts; herpes; erectile dysfunction; or any other disease or disorder of the genital or reproductive system? Yes No

S. For all FEMALE persons applying (adults and children)
a) Fibroid or uterine tumor; ovarian cyst; endometriosis; cystocele; rectocele; sexually transmitted disease; genital warts; herpes; HPV; or any other disease or disorder of the genital or reproductive system?..... Yes No
b) Has any female person had a C-section? Yes No
c) Has any female person had a pap smear? Yes No
If "Yes" for pap, provide the date and results of each person's last 2 paps:
Name: _____ Date: _____ Normal Abnormal
Name: _____ Date: _____ Normal Abnormal
Name: _____ Date: _____ Normal Abnormal
Name: _____ Date: _____ Normal Abnormal
Name: _____ Date: _____ Normal Abnormal
Name: _____ Date: _____ Normal Abnormal

2. **For EACH person applying for coverage (adults and children),** complete the following information regarding their last physical exam including checkup:

Person's Name: _____ Exam Date (Month/Year): ____/____/____ **Exam Results:** Normal Abnormal*
Person's Name: _____ Exam Date (Month/Year): ____/____/____ **Exam Results:** Normal Abnormal*
Person's Name: _____ Exam Date (Month/Year): ____/____/____ **Exam Results:** Normal Abnormal*
Person's Name: _____ Exam Date (Month/Year): ____/____/____ **Exam Results:** Normal Abnormal*
Person's Name: _____ Exam Date (Month/Year): ____/____/____ **Exam Results:** Normal Abnormal*

*Abnormal exam results include any recommendation for additional testing, medication or follow-up visit(s).

3. **During the last 5 years,** has any person applying for coverage had an **abnormal** result from a physical exam, blood test, urinalysis, lab or diagnostic test? Yes No

4. **During the last 12 months,** has any person applying for coverage been prescribed or advised to take medication (other than for the common cold or flu) that is not indicated elsewhere on this application? *If unsure of the reason for any ongoing medication use, please verify with your physician.* Yes No

5. **During the last 12 months,** have you or your spouse (if to be insured) smoked or used any tobacco product – such as cigarettes, pipes, cigars, snuff or chewing tobacco, or used any smoking cessation aid or nicotine substitution product? **YOU**..... Yes No
YOUR SPOUSE..... Yes No

6. A. Question for all FEMALE persons applying (including dependents) Is any female applying for coverage now pregnant or now an expectant parent? **If "Yes", coverage cannot be offered.**..... Yes No

B. Question for all MALE persons applying (including dependents) Is any male applying for coverage now an expectant parent? **If "Yes", coverage cannot be offered.** Yes No

7. Has any person applying for coverage **ever** been seen, tested, prescribed or taken medication, or treated for infertility or to assist in becoming pregnant? Yes No

8. A. Does any person applying for coverage **have or ever had** an implant (e.g. breast, chin or penile implant, etc.), internal fixation (e.g. pins, plates, rods, screws or spinal cage), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device other than indicated elsewhere on this application? Yes No

If "Yes" to breast implants:

B. Indicate reason(s) for breast implants: **Cosmetic Reasons** **Disease/Illness/Injury/Congenital Anomaly**

C. Have there been any complications or have either of the breast implant(s) been replaced?..... Yes No

9. A. Does any person applying for coverage drink beer or alcohol? Yes No
If "Yes", please complete the following:

Person's Name: _____ Average number of drinks per week: _____

Person's Name: _____ Average number of drinks per week: _____

Person's Name: _____ Average number of drinks per week: _____

Person's Name: _____ Average number of drinks per week: _____

(Note: One drink is equivalent to one 12 oz. beer, or one 5 oz. glass of wine, or 1.5 oz. of hard liquor.)

B. Has any person applying for coverage **ever** been advised to seek treatment for alcohol use or been advised to reduce alcohol intake, or been counseled for, diagnosed with, or treated for alcohol use or abuse, alcohol dependency or alcoholism? Yes No

10. Has any person applying for coverage **ever** used illegal drugs or substances or been counseled for, diagnosed with, or treated for drug or chemical use (prescription, non-prescription, or illegal), or dependency? Yes No

11. Has any person applying for coverage discussed or been advised to have treatment, testing, counseling, therapy, or surgery **which has not yet been performed?** Yes No

12. Has any person applying for coverage **ever** been seen, treated, hospitalized, or had surgery for a bypass, angioplasty, stent, aneurysm, valve replacement, cancer, stroke, gastric or weight loss surgery, congenital abnormality, or organ transplant other than indicated elsewhere on this application?..... Yes No

SECTION F – OTHER INSURANCE INFORMATION

1. Does any person applying for coverage currently have, or did they previously have **within the last 5 years**, Blue Cross and Blue Shield of Illinois coverage, either as a primary insured, spouse or as a dependent? Yes No *If "Yes", please complete the following:*

Applicant Name _____ Name on Previous Policy (if applicable) _____ Member/Group No. (optional) _____

Applicant Name _____ Name on Previous Policy (if applicable) _____ Member/Group No. (optional) _____

2. Does any person applying for coverage currently have health or major medical insurance coverage with any other Insurer, including other Blue Cross and Blue Shield plans? Yes No *If "Yes", please complete the following:*

Name(s) of all individuals covered: _____

Insurer Name(s): _____ Location / State: _____

Policy Effective Date: _____ Anticipated Policy Termination Date: _____

3. If "Yes" to either question 1 or 2 above, is the issuance of this coverage replacing your existing coverage? Yes No

If "Yes", when is coverage to be replaced (mo./day/yr.)? _____ / _____ / _____

If "No", please explain _____

4. Has any person applying for coverage ever been declined, postponed, charged an extra premium for or had a rider applied to life, health, or disability insurance, or had any such insurance rescinded or cancelled? Yes No

If "Yes", please explain _____

Note: Do not cancel any current coverage you may have until your new policy is approved and in force.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

If you answered "Yes" to Question 3 above, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a contract to be issued by Blue Cross and Blue Shield of Illinois. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new contract.

1. Health conditions which you may presently have may not be immediately or fully covered under the new contract. This could result in denial or delay of a claim for benefits under the new contract, whereas a similar claim might have been payable under your present contract.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present contract. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present contract and replace it with new coverage, be certain to truthfully and completely answer all questions on this application concerning the medical/health history of all persons applying for coverage. Failure to include all material medical information on any application may provide the basis for the company to deny any future claims and to refund your premium as though your contract had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended, that you not terminate your present contract until you are certain that your application for the new contract has been accepted by Blue Cross and Blue Shield of Illinois.

SECTION G – REPRESENTATIONS, ACKNOWLEDGEMENTS, AND AUTHORIZATIONS

I apply for coverage as indicated in Section B, for which I am or may become eligible under the agreement with Health Care Service Corporation (providing hospital and medical coverage) which is herein called the Company. **I have read all the statements in this application, and represent that they are true and complete to the best of my knowledge and belief. I understand that failure to disclose information on this application may be the basis for future claim denial, rescission or reformation as of the original effective date, solely at the discretion of the Company.**

I have read and understand the Outline of Coverage that has been provided to me. I have been informed of the provisions of the Blue Cross and Blue Shield of Illinois health plan and the Medical Services Advisory (MSA[®]) Program (along with the provisions of the Mental Health Unit if applicable).

If requesting List Bill, I direct my employer to deduct from my pay and remit the entire cost of coverage selected. This authorization is to remain in effect until the Company is notified by me or my employer in writing to the contrary. I understand that the insurance plan applied for is **not** an employer-sponsored group health plan and it **does not** comply with state or federal small employer laws even if I have requested List Bill.

Medical Authorization: I authorize any medical professional, hospital, clinic, pharmacy, pharmacy benefits manager or other pharmacy-related services organization, health plan, or other medical or medically related facility, governmental agency or other person or firm, to disclose to the Company or their authorized representative, information, including copies of records, concerning advice, care or treatment provided to me and/or my dependents, including without limitation, information relating to the use of drugs or alcohol. I also authorize the release of information relating to mental illness. In addition, I authorize the Company to review and research its own records for information.



Applicant Name _____

SECTION G – (Continued)

I understand my authorization is voluntary and that such information will be used by the Company for the purpose of evaluating my application for health insurance. Further, I understand that my authorization is required for the Company to consider my application and to determine whether or not an offer of coverage will be made. No action will be taken on my application without my signed authorization. I understand information obtained with my authorization may be re-disclosed by the Company as permitted or required by law and no longer protected by the federal privacy laws.

I understand that I or any authorized representative will receive a copy of this authorization upon request. This authorization is valid from the date signed and, provided the Company approves coverage, until a policy is put in force unless revoked by me in writing, which I may do at any time. Any revocation will not affect the activities of the Company prior to the date such revocation is received by the Company.

APPLICANT'S SIGNATURE(S)

IMPORTANT: Your application must be signed and dated by all applicants as required. (This includes your spouse and all dependents age 18 or over who are applying for coverage.) Missing signatures or dates will cause a delay in processing. We must also receive your application within 30 days of the earliest date signed, so please return promptly. Applications received after 30 days will require a new application.

Primary Applicant Signature: **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Spouse Signature
(ONLY if to be insured): **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Parent/Guardian Signature
(If Primary Applicant is UNDER the age of 18): **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Dependent Signature
(ONLY if 18 or over and ONLY if to be insured): **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

If any question(s), you may (1) call our Customer Service Department toll-free at **1-800-654-7385**, or (2) call your insurance agent at their number below, or (3) visit **www.bcbsil.com**.

PROXY The undersigned hereby appoints the Board of Directors of Health Care Service Corporation, a Mutual Legal Reserve Company, or any successor thereof ("HCSC"), with full power of substitution, and such persons as the Board of Directors may designate by resolution, as the undersigned's proxy to act on behalf of the undersigned at all meetings of members of HCSC (and at all meetings of members of any successor of HCSC) and any adjournments thereof, with full power to vote on behalf of the undersigned on all matters that may come before any such meeting and any adjournment thereof. The annual meeting of members shall be held each year in the corporate headquarters on the last Tuesday of October at 12:30 p.m. Special meetings of members may be called pursuant to notice mailed to the member not less than 30 nor more than 60 days prior to such meetings. This proxy shall remain in effect until revoked in writing by the undersigned at least 20 days prior to any meeting of members, or by attending and voting in person at any annual or special meeting of members.

Primary Applicant Signature (optional): **X** _____

Print Your Name as You Signed It: _____ Date Signed: ____/____/____
Mo./Day/Yr.

SECTION H – AGENT INFORMATION (if applicable)

The applicant acknowledges that any agent is acting on his/her behalf for purposes of purchasing the insurance, and that if HCSC accepts this application and issues an Individual Policy, HCSC may pay the agent a commission and/or other compensation in connection with the insurance of such Individual Policy. The applicant further acknowledges that if he/she desires additional information regarding any commissions or other compensation paid the agent by HCSC in connection with the issuance of the Individual Policy, he/she should contact the agent.

Agent Signature: **X** _____ Date Signed: ____/____/____
Mo./Day/Yr.

Print Agent Name: **Ryan Kennelly** Agent Code: **000628138**

Agent Phone Number: (**630**) **930-9364** Agent Fax Number: (**847**) **220-9280**

Agent Email Address: **ryan@ilhealthagents.com** Mail Policy(ies) to: Agent Applicant

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

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