BlueCross BlueShield of Illinois

Enrollment and Change Form

Administrative Offices: 701 E. 22nd Street, Lombard, IL 60148

☐ New Enrollment ☐ Change ☐ Open Enrollment ☐ COBRA ☐ Retiree

Employer/Employee Section

Enrollment forms must be submitted directly to us unless the group is self-administered. If the group is self-administered, submit enrollment forms to us only if evidence of insurability is required.

EMPLOYER	GROUP NO. / ACCOUNT NUMBER	LOCATION
American Library Association	F023261	

EMPLOYEE NAME - LAST	FIRST	MIDDLE INITIAL	GENDER ☐ M ☐ F	DATE OF BIRTH	DATE OF HIRE (FULL TIME)

SOCIAL SECURITY NO.	EARNINGS Hourly ☐ Weekly ☐ Monthly ☐ Annual ☐	JOB TITLE	CLASS

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	WORK PHONE	CELL PHONE

BENEFIT SELECTION - Life & Disability

COVERAGE SELECTION: Your non-medical group insurance program may not include all the benefits listed below. **Ask your employer for the details about the benefits available to you, your cost, if any, and whether you will be required to complete a health questionnaire.**

Basic Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.

☒ Term Life / AD&D	☒ Long-Term Disability (LTD)

Supplemental Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Term Life	Employee			
☐ Term Life	Spouse			
☐ Term Life	Child(ren)			
Voluntary Coverage (check all that apply) Spouse includes Domestic Partner and Party to a Civil Union as defined in the Certificate.		(A)Add, (C)Change (D)Delete	Total Amount of Coverage Desired	If (C)hange, list Prior Coverage
☐ Short-Term Disability (STD): % of Earnings				

SPOUSE NAME (if Applicant)	- LAST	FIRST	M.I.	SEX ☐ M ☐ F	SPOUSE DATE OF BIRTH	SPOUSE SOCIAL SECURITY #

BENEFICIARY DESIGNATION: (For Employee Only: Must Be Completed if you have applied for Life or AD&D insurance.) If two or more primary beneficiaries are named, and you do not list benefit percentages, proceeds will be paid in equal shares to the named primary beneficiaries who survive you. If no primary beneficiary survives you, proceeds will be paid to the contingent beneficiary(ies). If you list benefit percentages, the total must equal 100%. (Employee is the beneficiary of proceeds from spouse or child coverage.)

First Name Last Name	Social Security No.	Date of Birth	Relationship	Percentage
Primary				%
Primary				%
Contingent				%
Contingent				%

I hereby request to be insured and authorize deductions, if any, from my compensation for my share of the cost of the benefits to which I may be entitled under the group policy (ies) issued to the employer listed above. I understand that if I am not actively at work on the effective date of my coverage, my insurance will not begin until the day I return to work. I understand that if I do not remain actively at work that my coverage may lapse or terminate. For those coverages I have declined, I understand that if I choose to enroll at a later date, my cost may be higher and a health questionnaire may be required.

FOR OFFICE USE ONLY

EMPLOYEE SIGNATURE _____ DATE ___/___/_____

Waiver of Coverage:

I DO NOT WISH TO ENROLL at this time and understand that the opportunity to enroll at any future time will be subject to such arrangements as may be made with the company.

EMPLOYEE SIGNATURE _____ DATE ___/___/_____