EMPLOYEE INFORMATION STATEMENT FOR HEALTH INSURANCE BENEFITS

BRADLEY University

Please provide the information requested below for yourself and each eligible dependent covered under the **Bradley University Health Plan**. *By supplying all of the information at this time, it avoids the necessity of completing this form if dependents, listed below, should have a claim this year.*
PLEASE PRINT CLEARLY AND USE INK.

New enrollment effective_____
Change effective _____
Add dependent(s) effective _____
Cancel dependent(s) effective _____

Employee MUST Complete:

[ ] **I select the PPO Plan,**
or
[ ] **I select the Qualified High Deductible Health Plan**

(Please check one) **[ ] ACTIVE EMPLOYEE** **[ ] RETIREE** **[ ] COBRA**

NAME (GIVE FULL LEGAL NAME)	[ ] MALE [ ] FEMALE	BIRTHDATE	SOCIAL SECURITY NO.

ADDRESS: STREET AND NO.	CITY	STATE	ZIP CODE	TELEPHONE NO.

STATUS: [ ]Single [ ]Married [ ] Divorced [ ] Widowed	DATE OF MARRIAGE:	DATE OF FULL-TIME EMPLOYMENT:

CHOOSE APPLICABLE COVERAGE / WAIVER:

	Employee Only	Employee + 1 dependent	Employee + 2 or more dependents	*OR*	Decline Coverage
MEDICAL, RX and DENTAL :	[ ]	[ ]	[ ]		[ ]

DO YOU HAVE OTHER GROUP HEALTH INSURANCE COVERAGE? [ ] NO [ ] YES | **DO YOU HAVE MEDICARE COVERAGE? [ ] NO [ ] YES, Medicare ID #A** _____

SPOUSE'S NAME— ONLY IF COVERING ON BU PLAN:	[ ] MALE [ ] FEMALE	BIRTHDATE	SOCIAL SECURITY NO.

NAME OF SPOUSE'S EMPLOYER:	EMPLOYER'S ADDRESS: STREET & NO.	CITY STATE ZIP

DOES YOUR SPOUSE HAVE MEDICARE COVERAGE? [ ] NO [ ] YES, MEDICARE ID Number: #A_____ Effective: _____	DOES YOUR SPOUSE HAVE OTHER GROUP HEALTH COVERAGE? [ ] NO [ ] YES (IF "YES", PLEASE ANSWER BELOW) SPOUSE"S COVERAGE? [ ] SINGLE [ ] FAMILY [ ] MEDICAL [ ] DENTAL

NAME OF SPOUSE"S INSURANCE COMPANY	ADDRESS WHERE CLAIMS ARE SUBMITTED

DEPENDENT CHILDREN - ONLY IF COVERING ON BU PLAN (Include last name if different than Employee's last name):

1. DEPENDENT'S NAME	[ ] MALE [ ] FEMALE	RELATIONSHIP:	BIRTHDATE

OTHER COVERAGE? [ ] YES [ ] NO If yes, complete below information for other insurance.	SOCIAL SECURITY NUMBER:	NAME OF SCHOOL OR EMPLOYER:
	DEPENDENT'S ADDRESS	CITY STATE ZIP

2. DEPENDENT'S NAME	[ ] MALE [ ] FEMALE	RELATIONSHIP:	BIRTHDATE

OTHER COVERAGE? [ ] YES [ ] NO If yes, complete below information for other insurance.	SOCIAL SECURITY NUMBER:	NAME OF SCHOOL OR EMPLOYER:
	DEPENDENT'S ADDRESS	CITY STATE ZIP

3. DEPENDENT'S NAME	[ ] MALE [ ] FEMALE	RELATIONSHIP:	BIRTHDATE

OTHER COVERAGE? [ ] YES [ ] NO If yes, complete below information for other insurance.	SOCIAL SECURITY NUMBER:	NAME OF SCHOOL OR EMPLOYER:
	DEPENDENT'S ADDRESS	CITY STATE ZIP

4. DEPENDENT'S NAME	[ ] MALE [ ] FEMALE	RELATIONSHIP:	BIRTHDATE

OTHER COVERAGE? [ ] YES [ ] NO If yes, complete below information for other insurance.	SOCIAL SECURITY NUMBER:	NAME OF SCHOOL OR EMPLOYER:
	DEPENDENT'S ADDRESS	CITY STATE ZIP

DO YOU OR ANY OF YOUR DEPENDENTS HAVE ***ANY OTHER*** GROUP HEALTH INSURANCE COVERAGE? [ ] NO [ ] YES — PROVIDE INFORMATION BELOW.

IF ANY DEPENDENT HAS EITHER SCHOOL OR OTHER GROUP HEALTH INSURANCE, INDICATE:

(1) NAME OF DEPENDENT _____
(2) NAME OF THE POLICYHOLDER/GROUP _____
(3) INSURED _____
(4) HIS/HER INSURANCE IDENTIFICATION NUMBERS _____
(5) NAME OF HIS/HER INSURANCE COMPANY _____
(6) FULL ADDRESS OF INSURANCE COMPANY WHERE CLAIMS ARE PROCESSED _____

I hereby request the amount(s) and form(s) of coverage for which I am or may become eligible and I hereby authorize my employer to deduct the required contributions, if any, from my earnings. Additionally, I certify that the above information is true and correct. I hereby authorize all doctors, pharmacists, hospitals or other institutions rendering care and treatment to me or any of my eligible dependents to furnish BCBSIL and/or its Designee with full information regarding treatment rendered (including copies of their records), for the purpose of claims payment, eligibility determination and/or utilization review/case management, if appliable. I may also authorize any Union, Trust Fund, Employer or Insurance Carrier to furnish BCBSIL and/or its Designee with information regarding benefits to which I may be entitled. If I declined to participate, (individually or for an eligible dependent), I understand that should I desire coverage at a later day, coverage may not be available. (See NOTICE on reverse side for additional information.) I understand that the listing of my spouse and children on this form does not automatically qualify them as eligible dependents under the plan and that it is my responsibility to verify their eligibility for benefits under the terms of this plan. I agree that this authorization shall be in force until released by me in writing (or a new one signed). I further understand that if I receive treatment without following the precertification procedure, I may be responsible for paying more of my hospital bill. A photostatic copy of this authorization shall be as effective and valid as the original. I CERTIFY THAT I HAVE READ THE NOTICE PRINTED ON THE REVERSE SIDE.

DATE:_____ **EMPLOYEE SIGNATURE:** _____

SEND ORIGINAL TO: BRADLEY UNIVERSITY Attn: HR DEPARTMENT, 239 Sisson Hall (form revised 8-16)