

GROUP #	SECTION #	SOC. SEC. #	ACCOUNT #	CATEGORY
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SECTION 1 — ENROLLMENT EVENTS PLEASE CHECK ALL THAT APPLY – IF YOU ARE DECLINING COVERAGE, COMPLETE SECTIONS 2, 8 AND 9 ONLY

<input type="checkbox"/> NEW ENROLLEE <input type="checkbox"/> ADD DEPENDENT <input type="checkbox"/> OPEN ENROLLMENT <input type="checkbox"/> OTHER CHANGES ARE YOU APPLYING AS A RESULT OF A SPECIAL ENROLLMENT EVENT? <input type="checkbox"/> NO <input type="checkbox"/> YES, EVENT DATE: EVENT: <input type="checkbox"/> NEW HIRE <input type="checkbox"/> MARRIAGE* <input type="checkbox"/> BIRTH <input type="checkbox"/> ADOPTION, PLACEMENT FOR ADOPTION OR SUIT FOR ADOPTION (PROVIDE LEGAL DOCUMENTS) <input type="checkbox"/> COURT ORDER (PROVIDE COURT ORDER OR DECREE) <input type="checkbox"/> LOSS OF OTHER COVERAGE <input type="checkbox"/> OTHER (EXPLAIN): EFFECTIVE DATE OF BENEFITS: <input type="checkbox"/> COMPLETION OF OTHER ELIGIBILITY REQUIREMENTS	<input type="checkbox"/> CANCEL ENROLLEE <input type="checkbox"/> CANCEL DEPENDENT CANCEL COVERAGE: <input type="checkbox"/> HEALTH <input type="checkbox"/> DENTAL <input type="checkbox"/> TERM LIFE <input type="checkbox"/> DEPENDENT LIFE <input type="checkbox"/> SHORT-TERM DISABILITY <input type="checkbox"/> LONG-TERM DISABILITY LIST NAMES OF THOSE CANCELING IN SECTION 4 BELOW EVENT: <input type="checkbox"/> DIVORCE** <input type="checkbox"/> DEATH <input type="checkbox"/> TERMINATED EMPLOYMENT <input type="checkbox"/> OTHER INDICATE EVENT DATE:
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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		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HOME/CELL PHONE #		
NAME OF EMPLOYER	JOB TITLE	BUSINESS PHONE #	EMPLOYMENT DATE (MM/DD/YYYY)	ON AVERAGE, HOW MANY HOURS A WEEK DO YOU WORK? (REQUIRED)	
ELIGIBILITY STATUS: <input type="checkbox"/> ACTIVE EMPLOYEE <input type="checkbox"/> RETIRED EMPLOYEE - DATE OF RETIREMENT:		<input type="checkbox"/> COBRA COVERAGE START DATE		PROJECTED END DATE	
<input type="checkbox"/> 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 <input type="checkbox"/> PPO <input type="checkbox"/> OTHER <input type="checkbox"/> BLUE CHOICE PREFERRED PPO SM <input type="checkbox"/> BLUE OPTIONS SM <input type="checkbox"/> BLUE PRECISION HMO SM <input type="checkbox"/> BLUECARE DIRECT SM PLAN # (REQUIRED)	GRANDFATHERED AND GRANDMOTHERED/TRANSITIONAL PLANS <input type="checkbox"/> BLUE ADVANTAGE ENTREPRENEUR PPO SM <input type="checkbox"/> BLUE ADVANTAGE HMO SM <input type="checkbox"/> BLUE CHOICE SELECT PPO SM <input type="checkbox"/> BLUE ADVANTAGE HMO VALUE CHOICE SM <input type="checkbox"/> BLUE EDGE SELECT HSA SM <input type="checkbox"/> COMMUNITY PARTICIPATION ORGANIZATION (CPO) <input type="checkbox"/> BLUE EDGE HSA SM <input type="checkbox"/> CPO VALUE CHOICE <input type="checkbox"/> BLUE EDGE HCA DIRECT SM <input type="checkbox"/> OTHER <input type="checkbox"/> PPO VALUE CHOICE PLAN # (REQUIRED)
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MID-MARKET AND LARGE GROUP STANDARD PLANS (51+ EMPLOYEES) PREVIOUS BCBSIL OR HMO MEMBERSHIP

MID-MARKET & LARGE GROUP STANDARD PLANS 51+ <input type="checkbox"/> PPO <input type="checkbox"/> BLUE CHOICE OPTIONS SM <input type="checkbox"/> BLUE EDGE SELECT HSA SM <input type="checkbox"/> BLUE ADVANTAGE HMO SM <input type="checkbox"/> BLUE CHOICE SELECT PPO SM <input type="checkbox"/> PLAN # (REQUIRED) <input type="checkbox"/> BLUE ADVANTAGE HMO VALUE CHOICE SM <input type="checkbox"/> BLUE EDGE HSA SM <input type="checkbox"/> OTHER	GROUP #: SECTION #: IDENTIFICATION #:
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LARGE GROUP CUSTOM PLANS (151+ EMPLOYEES)

<input type="checkbox"/> TRADITIONAL <input type="checkbox"/> BLUE ADVANTAGE HMO SM W/HCA <input type="checkbox"/> PPO <input type="checkbox"/> BLUE CHOICE OPTIONS SM <input type="checkbox"/> CPO <input type="checkbox"/> BLUE CHOICE SELECT PPO SM <input type="checkbox"/> CPO VALUE CHOICE <input type="checkbox"/> BLUE EDGE HCA SM <input type="checkbox"/> HMO ILLINOIS [®] <input type="checkbox"/> BLUE EDGE HSA SM <input type="checkbox"/> HMO ILLINOIS [®] W/HCA <input type="checkbox"/> BLUE EDGE HCA DIRECT SM <input type="checkbox"/> BLUE ADVANTAGE HMO SM <input type="checkbox"/> BLUE EDGE SELECT HCA SM	<input type="checkbox"/> BLUE EDGE SELECT HSA SM <input type="checkbox"/> BLUE EDGE SELECT HCA DIRECT SM <input type="checkbox"/> VISION <input type="checkbox"/> HEARING <input type="checkbox"/> MEDICARE SUPPLEMENT <input type="checkbox"/> OTHER
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DENTAL

<input type="checkbox"/> BLUECARE DENTAL PPO SM <input type="checkbox"/> BLUECARE DENTAL HMO SM <input type="checkbox"/> DENTAL GROUP # (IF DIFFERENT THAN MEDICAL GROUP POLICY #)	<input type="checkbox"/> EMPLOYEE AND PARTY TO A CIVIL UNION OR DOMESTIC PARTNER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	<input type="checkbox"/> INDIVIDUAL/EMPLOYEE <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/CHILDREN <input type="checkbox"/> FAMILY
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PRIMARY LANGUAGE

GROUP TERM LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) AND DISABILITY INSURANCE

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

PRIMARY BENEFICIARY	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
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CONTINGENT BENEFICIARY	FIRST NAME	INITIAL	LAST NAME	RELATIONSHIP	BIRTH DATE (MM/DD/YYYY)	SOCIAL SECURITY #
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LAST NAME	SOC. SEC. #	GROUP #
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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? <input type="checkbox"/> YES <input type="checkbox"/> NO	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #		
DEPENDENT'S NAME <input type="checkbox"/> HUSBAND <input type="checkbox"/> WIFE <input type="checkbox"/> DOMESTIC PARTNER <input type="checkbox"/> PARTY TO A CIVIL UNION		DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER ELIGIBLE DEPENDENT		DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S SOCIAL SECURITY #	IPA NAME IPA #	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #		
DEPENDENT'S NAME <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER ELIGIBLE DEPENDENT		DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S SOCIAL SECURITY #	IPA NAME IPA #	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #		
DEPENDENT'S NAME <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER ELIGIBLE DEPENDENT		DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DEPENDENT'S SOCIAL SECURITY #	IPA NAME IPA #	HMO OB/GYN NAME (OPTIONAL)	HMO OB/GYN #		
DEPENDENT'S NAME <input type="checkbox"/> SON <input type="checkbox"/> DAUGHTER <input type="checkbox"/> OTHER ELIGIBLE DEPENDENT		DEPENDENT'S PCP NAME	PCP #	NEW PATIENT? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> YES <input type="checkbox"/> NO	INDIVIDUAL COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	NAME AND ADDRESS OF OTHER INSURANCE CARRIER	EFFECTIVE DATE (MM/DD/YYYY)	TYPE OF POLICY <input type="checkbox"/> EMPLOYEE ONLY <input type="checkbox"/> EMPLOYEE/SPOUSE <input type="checkbox"/> EMPLOYEE/CHILD(REN) <input type="checkbox"/> FAMILY	
NAME OF POLICYHOLDER		BIRTH DATE (MM/DD/YYYY)	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE		RELATIONSHIP TO APPLICANT <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> 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 HIC # (FROM MEDICARE CARD)	
	MEDICARE B (MEDICAL) EFFECTIVE DATE:	END DATE:		
	MEDICARE D (DRUG) EFFECTIVE DATE:	END DATE:		
	MEDICARE D (DRUG) CARRIER:			
PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: <input type="checkbox"/> ENTITLED AGE <input type="checkbox"/> ENTITLED DISABILITY <input type="checkbox"/> END-STAGE RENAL DISEASE <input type="checkbox"/> DISABILITY AND CURRENT RENAL DISEASE				
NAME OF PERSON COVERED:	MEDICARE A (HOSPITAL) EFFECTIVE DATE:	END DATE:	MEDICARE HIC # (FROM MEDICARE CARD)	
	MEDICARE B (MEDICAL) EFFECTIVE DATE:	END DATE:		
	MEDICARE D (DRUG) EFFECTIVE DATE:	END DATE:		
	MEDICARE D (DRUG) CARRIER:			
PLEASE INDICATE REASON FOR MEDICARE ELIGIBILITY: <input type="checkbox"/> ENTITLED AGE <input type="checkbox"/> ENTITLED DISABILITY <input type="checkbox"/> END-STAGE RENAL DISEASE <input type="checkbox"/> DISABILITY AND CURRENT RENAL DISEASE				

LAST NAME	SOC. SEC. #	GROUP #
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SECTION 8 — DECLINATION OF COVERAGE	PLEASE COMPLETE IF YOU ARE DECLINING COVERAGE
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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.

NAME <input type="checkbox"/> EMPLOYEE	REASON FOR DECLINING HEALTH: <input type="checkbox"/> OTHER GROUP HEALTH COVERAGE – CARRIER: <input type="checkbox"/> MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> OTHER INDIVIDUAL HEALTH COVERAGE – CARRIER: <input type="checkbox"/> OTHER (EXPLAIN) <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME <input type="checkbox"/> EMPLOYEE	REASON FOR DECLINING DENTAL: <input type="checkbox"/> OTHER GROUP DENTAL COVERAGE <input type="checkbox"/> MEDICAID <input type="checkbox"/> INDIVIDUAL DENTAL COVERAGE <input type="checkbox"/> OTHER (EXPLAIN) <input type="checkbox"/> I AM NOT ENROLLED IN ANY DENTAL INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME <input type="checkbox"/> SPOUSE	REASON FOR DECLINING: <input type="checkbox"/> OTHER GROUP HEALTH COVERAGE <input type="checkbox"/> MEDICAID <input type="checkbox"/> INDIVIDUAL HEALTH COVERAGE <input type="checkbox"/> OTHER (EXPLAIN) <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME <input type="checkbox"/> DEPENDENT	REASON FOR DECLINING: <input type="checkbox"/> OTHER GROUP HEALTH COVERAGE <input type="checkbox"/> MEDICAID <input type="checkbox"/> INDIVIDUAL HEALTH COVERAGE <input type="checkbox"/> OTHER (EXPLAIN) <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE
NAME <input type="checkbox"/> DEPENDENT	REASON FOR DECLINING: <input type="checkbox"/> OTHER GROUP HEALTH COVERAGE <input type="checkbox"/> MEDICAID <input type="checkbox"/> INDIVIDUAL HEALTH COVERAGE <input type="checkbox"/> OTHER (EXPLAIN) <input type="checkbox"/> I AM NOT ENROLLED IN ANY HEALTH INSURANCE PLAN, BUT DO NOT WANT THIS COVERAGE

SECTION 9 — COVERAGE CONDITIONS
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- 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 300 E. Randolph St. 35th Floor Chicago, Illinois 60601	Phone: 855-664-7270 (voicemail) TTY/TDD: 855-661-6965 Fax: 855-661-6960 Email: CivilRightsCoordinator@hcsc.net
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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 200 Independence Avenue SW Room 509F, HHH Building 1019 Washington, DC 20201	Phone: 800-368-1019 TTY/TDD: 800-537-7697 Fax: 855-661-6960 Complaint Portal: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf Complaint Forms: http://www.hhs.gov/ocr/office/file/index.html
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