



(For COBRA requests, go to <http://bcbsil.com/employer/newsupdate/cobra.htm> or contact your group administrator)

Date: _____

Group number: _____ Subscriber number: _____

Employer name: _____

Group Contact Name: _____ Phone number: _____

Email copy of notification letter to Group: YES NO Contact Email Address: _____

BCBSIL Membership Services (FSU):

Please be advised of a member's request concerning the right to continue health insurance per the Illinois Continuation Privilege or mandate. Please forward required notice and election forms.

QUALIFYING EVENT: _____

EVENT EFFECTIVE DATE: _____

NAME OF PERSON TO BE NOTIFIED (please print): _____

SOCIAL SECURITY NUMBER (required): _____ DATE OF BIRTH: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TYPE OF CONTINUATION NOTICE

(select one)

<input type="checkbox"/> Spousal	<input type="checkbox"/> Dependent Child	<input type="checkbox"/> Deputy	<input type="checkbox"/> Police Officer	<input type="checkbox"/> Fireman	<input type="checkbox"/> Municipal Employee
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COVERAGE TIER

<input type="checkbox"/> Self	<input type="checkbox"/> Self + Spouse	<input type="checkbox"/> Self + Children	<input type="checkbox"/> Self + Family
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LIST ANY ADDITIONAL DEPENDENTS TO BE INSURED

Name	Relationship	Date of Birth (MM/DD/YYYY)

Please return the completed request form by using one of the suggested methods as noted below.

*For confirmation of faxed and mailed requests, please contact your FSU**

Email (preferred method)	Fax*	U.S. Mail*
ILStateContinuation@bcbsil.com	1-618-998-2747	Illinois Continuation Service Unit PO Box 655082 Dallas, TX 75265-5082

24044.0212