

# IXSolutions Health Insurance Enrollment Instructions

For Blue Cross Blue  
Shield of Illinois

## Link to Shop plans and Start Enrollment

Enrollment for your Blue Cross Blue Shield plan will be completed online by clicking the link below:

<https://qt.trionfoconnect.com/IX/Individual>

## Network Options

When enrolling into a health insurance plan, you will have an option to select between 3 different network options: BlueCare Direct, Blue Precision HMO, and Blue Choice Preferred PPO. *Please consult with your current doctors and specialists to see if they accept the following individual networks offered by Blue Cross Blue Shield of Illinois.*

**BlueCare Direct** is in collaboration with Advocate doctors and hospitals only. Choose this plan if your preferred doctors and hospitals are part of the Advocate Healthcare system.

**Blue Precision HMO** is a statewide HMO network. You will have to select a primary care physician that accepts Blue Precision HMO. For example, Silver Cross Hospital and Presence Saint Joseph Medical center are both in-network hospitals for this network.

**Blue Choice Preferred PPO** is the narrow PPO network that doesn't require referral from your primary care physician.

**Here is the link to search doctors and hospitals:**

<https://public.hcsc.net/providerfinder/search.do?corpEntCd=IL1>

Make sure when you are searching doc/hospitals, that you are selecting the appropriate network (BlueCare Direct, Blue Precision HMO, Blue Choice Preferred PPO), see example below:

### Select Network or Plan

Choose your plan network (or plan name) from the choice

[Which network covers your plan?](#)

Looking for a Medicare provider? Start [here](#)

Plan Networks  Individual & Family Plans

Blue Precision HMO<sup>sm</sup> [BAV]

## Step by Step instructions on how to use the online system:

**Step 1:** After clicking the link above, complete all the required fields circled below (if you want to include a dependent, please click the “Add Dependent” button).

### Get a Quote for Health

\* - Indicates a required field

Basic Information			
I'm looking for: *	Zip Code: *	County: *	
Health	60631	Cook	
Gender *	Date Of Birth: *	Desired Start Date: *	Tobacco Use? *
Male Female	11/11/1974	08/01/2017	Yes No
First Name:	Last Name:	Email:	Phone:
John	Doe	jdoe123@mxsail.com	(855) 563-6993

Census Information			
Relationship Type	Gender	Date Of Birth	Tobacco Use? Action
No Records			

click this button if you want to add dependents



**Step 2:** Now you can review your health plan choices. Once you decided on a plan, click “Add to Cart” and then scroll to the top and select “Check Out” (see image below).

No Records Found!

Email Quote

Check Out

You are currently shopping for

Health Medicare Dental Term Life Vision

21 Plans found Show all Plans

Sort By: Plan Cost

Company: Blue Cross and Blue Shield of Illinois (21)

Monthly Premium: \$330.00 - \$610.00 (330-610)

Annual Deductible: \$250.00 - \$7,100.00 (250-7100)

Coinsurance: 0% - 50% (0-50)

Network: HMO (14), PPO (7)

BlueCross BlueShield of Illinois

BlueCare Direct Bronze<sup>SM</sup> 103 with Advocate

\$335.50/month

Plan Type: HMO, Deductible: \$7,100, Coinsurance: 50%, Office Visit: \$50

Add to Cart

Compare, View Plan Details, Find Provider

BlueCross BlueShield of Illinois

Blue FocusCare Bronze<sup>SM</sup> 104

\$338.26/month

Plan Type: HMO, Deductible: \$7,100, Coinsurance: 50%

Add to Cart

Compare

Click "Check Out" after you add a plan to your cart.

Select Add to cart next to the health insurance plan you want.

**Step 3:** After selecting “Check Out”, you will be directed to the next page where you can begin your application process. Select “Begin Application”.

Plan Summary

Blue Precision Bronze HMO<sup>SM</sup> 103

BlueCross BlueShield of Illinois

Plan Type: HMO, Deductible: \$7,100, Coinsurance: 50%, Office Visit: \$50

Who is Covered?

Relationship	Date of Birth
Yourself	11/11/1974

\$372.78/month

Find Provider, Change Plan

Returning Visitors?

If you already have an account, please login to start or update your profile, manage your account and/or save plans.

Username: [Forgot Username], Password: [Forgot Password]

User Name, Password, Login To My Account

Back, Begin Application

**Step 4:** The next page will ask you to create an account. Please complete all the required fields highlighted below and then click “Register”:

### Create an Account

Creating an account will allow you to add family members, search for plans based on the information that you enter and track the status of your applications. Please enter your personal information below.

\* - Indicates a required field

<b>First Name: *</b> John	<b>Last Name: *</b> Doe	<b>Email Address: *</b> jdoe123@mxsail.com
<b>User Name: *</b> Jdoe123	<b>Password: *</b> .....	<b>Confirm Password: *</b> .....

Select two (2) challenge questions from the drop down lists and provide the answers for each. Enter an answer that only you will know.

<b>Security Question 01: *</b> In what city or town did your mother and father	<b>Your Answer 01: *</b> Chicago
<b>Security Question 02: *</b> What was your childhood nickname?	<b>Your Answer 02: *</b> Johnny

 Generate New Captcha

**Type the code from the Image \***  
ZGBNM

I have read and agree to be bound by the [Terms of Use](#) and [Privacy Policy](#)

[Back](#)

[Register](#)



**Step 5:** After clicking the “Register” button, you will be directed to the next page where you will be asked to complete your profile information. Please complete all fields that are marked with a red asterisk \*. Click “Save and Continue” after completing the required fields.

**Profile Information**

**Basic Information**

<b>First Name: *</b> John	<b>Middle Initial:</b> Middle Initial	<b>Last Name: *</b> Doe
<b>Gender: *</b> Male Female	<b>Date Of Birth: *</b> 11/11/1974	<b>Tobacco Use? *</b> Yes No
<b>Weight:</b> Weight lb	<b>Annual Household Income:</b> \$0.00	<b>Height:</b> Feet ft Inch in
<b>SSN: *</b> 455-46-5465	<b>SSN Last 4 Digit:</b> 5465	

**Contact Information**

<b>Primary Phone No: *</b> (855) 563-6993	<b>Best Time To Call: *</b> Morning
<b>Secondary Phone No:</b> Phone	<b>Best Time To Call:</b> Select
<b>Email Address: *</b> jdoe123@mxsail.com	

**Address Detail**  Same address for billing

<b>Address 1: *</b> 123 easy street	<b>Address 2:</b> Address 2	<b>City: *</b> chicago
<b>State: *</b> IL	<b>Zip Code: *</b> 60631	<b>County: *</b> Cook



**Step 6:** Next, you will be asked to verify you plan information. Verify that all the information on this page is correct and click “Continue”.

**Step 7:** Next, you will be asked to verify plan information. Click “Confirm Information” after you review and confirm the information in correct.

**Step 8:** The next step is to begin your E-Sign process which will include adding your banking information and for your electronic signature. To begin the process click “E-Sign” button on the bottom of the page.

Blue Cross Blue Shield of Illinois ^ Hide

Coverage: [Health](#)

Enrolling is Simple — Just Follow This Easy Process ...

**ATTENTION:** Your case may experience a delay if the required information is not complete.

**Complete the Application**

Be sure you follow the instructions on the application carefully. If you have any questions, or not sure how to answer a question, simply contact our customer service team. All new submissions must be completed in its entirety and signed prior to the requested effective date.

**Customer Service Team**

**Agency Name:** INSUREXHEALTH, LLC  
**Phone:** 855-563-6993  
**Email:** info@ixshealth.com

Thank you for your recent online transaction with INSUREXHEALTH, LLC. Upon receiving your application, we will send your application information over to the carrier for processing.

**Next Steps:**

A representative from the carrier or our team at INSUREXHEALTH, LLC will follow up with you shortly if additional information is needed to confirm your enrollment.

In the meantime, please call us for quick answers and immediate assistance.

We look forward to serving you.

E-Sign  


**Step 9:** Now you are at the last step of your enrollment. Here you will need to complete the required fields on the Blue Cross Blue Shield 2018 Individual Plan Application.

**(Page 1) Answer the questions below**

- o Do you have a preferred spoken language besides English
- o Do you have a disability affecting your ability to communicate or read? If yes, select the first button. If not, select the second button.

DO YOU HAVE A PREFERRED SPOKEN LANGUAGE BESIDES ENGLISH? <input checked="" type="radio"/> Y <input type="radio"/> N IF YES, PLEASE SPECIFY:		DO YOU HAVE A PREFERRED WRITTEN LANGUAGE BESIDES ENGLISH? <input type="radio"/> Y <input type="radio"/> N IF YES, PLEASE SPECIFY:	
*WITHIN THE PAST SIX MONTHS, HAVE YOU USED TOBACCO? 4 OR MORE TIMES PER WEEK ON AVERAGE, EXCLUDING RELIGIOUS OR CEREMONIAL USES <input type="checkbox"/> Y <input checked="" type="checkbox"/> N IF YES, PLEASE PROVIDE DATE OF LAST USE:		IF HISPANIC/LATINO, ETHNICITY (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> MEXICAN <input type="checkbox"/> MEXICAN AMERICAN <input type="checkbox"/> CHICANO/A <input type="checkbox"/> PUERTO RICAN <input type="checkbox"/> CUBAN <input type="checkbox"/> OTHER	
RACE (OPTIONAL—CHECK ALL THAT APPLY) <input type="checkbox"/> WHITE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> ASIAN INDIAN <input type="checkbox"/> CHINESE <input type="checkbox"/> FILIPINO <input type="checkbox"/> JAPANESE <input type="checkbox"/> KOREAN <input type="checkbox"/> VIETNAMESE <input type="checkbox"/> OTHER ASIAN <input type="checkbox"/> NATIVE HAWAIIAN <input type="checkbox"/> GUAMANIAN OR CHAMORRO <input type="checkbox"/> SAMOAN <input type="checkbox"/> OTHER PACIFIC ISLANDER <input type="checkbox"/> OTHER			
RESIDENTIAL ADDRESS - STREET, CITY, STATE, ZIP 123 easy street , chicago, IL, 60631			COUNTY Cook
MAILING ADDRESS - STREET, CITY, STATE, ZIP (IF DIFFERENT THAN ABOVE)			
PRIMARY PHONE (855) 563-6993		CELL <input type="radio"/> LANDLINE <input type="radio"/>	SECONDARY PHONE CELL <input type="radio"/> LANDLINE <input type="radio"/>
EMAIL ADDRESS jdoe123@mxsail.com		PREFERRED CONTACT METHOD <input type="checkbox"/> EMAIL <input type="checkbox"/> POSTAL MAIL	
MEDICAL GROUP** (FOR HMO ONLY)	MEDICAL GROUP# (FOR HMO ONLY)	DO YOU HAVE A DISABILITY AFFECTING YOUR ABILITY TO COMMUNICATE OR READ? (FOR HMO ONLY) IF "YES", DESCRIBE SPECIAL COMMUNICATION MATERIALS NEEDED: <input checked="" type="radio"/> Y <input type="radio"/> N	
SPOUSE AND/OR DEPENDENT CHILDREN TO BE COVERED (dependent children must be under age 26)			

## Next, proceed to page 5 “Section D: Billing Information”

All application must be submitted with payment information. You will have to enter your banking information on this page. Please check “Bank Draft” and “1-Month Bank Draft” along with entering your banking information. Refer to image below for required fields.

Section D: Billing Information Applicant Name:                       
SSN#: 455-46-5465

Note: Do not cancel any current coverage you may have until your application is approved and your new plan is effective.  
Please select one of the following options to make arrangements for paying your premium.

**BANK DRAFT**

1-MONTH BANK DRAFT (12 Payments Per Year)

**AUTHORIZATION AGREEMENT**  
Required for Bank Draft Payments Only  
I request and authorize BCBSIL and/or its designee to obtain payment of amounts becoming due by initiating charges to my account in the form of checks, share drafts, or electronic debit entries, and I request and authorize the Financial Institution named below to accept and honor the same to my account. I understand that this request for coverage is not an employer group health plan and is not intended, in any way, to be an employer-sponsored health insurance plan. I certify the employer(s) of those applying for coverage will not contribute any part of the premium, or provide reimbursement for any part of the premium now or in the future. I also understand that both the Financial Institution and BCBSIL reserve the right to terminate this payment program and/or my participation therein. To make changes to my Financial Institution I understand that I will need to provide at least 10 days advance notice to BCBSIL by telephone prior to a scheduled withdrawal date.

Please complete the following – print or type information  
I authorize BCBSIL to deduct the premium payments from my checking or savings account. If the draft date falls on a non-business day or a holiday, the premium payment will be deducted from my account on the next business day.  
*Please ensure adequate funds are available at the time of application. BCBSIL is not responsible for fees incurred due to insufficient funds.*

PLEASE CHECK ONE <input checked="" type="radio"/> CHECKING ACCOUNT <input type="radio"/> SAVINGS ACCOUNT	NAME OF DEPOSITOR(S) IF OTHER THAN THE APPLICANT
BANK TRANSIT NUMBER 071000013	DEPOSITOR'S ACCOUNT NUMBER 45565456
<input checked="" type="checkbox"/> I HAVE READ AND ACCEPT THE ABOVE AGREEMENT	
DEPOSITOR'S SIGNATURE <a href="#">Click here to sign</a>	DATE 07/21/2017
	RELATIONSHIP TO APPLICANT

**DIRECT BILLING**

→ if the bank information is from someone other than yourself

Make sure to click on Depositor's Signature to e-sign banking information (this is a required field). The sign your name, simply type your name in the signature box.

The screenshot shows the Adobe Sign interface. At the top, there's a toolbar with 'Type', 'Draw', 'Image', and 'Mobile' options. A signature box is open, containing the text 'john doe' in a cursive font. A red box highlights the signature area, and a red arrow points to the 'Sign' button. To the right of the signature box, there's a red text prompt: 'type depositor's name here'. Below the signature box, there's a 'Clear' button. The main form below has several sections:

- A 'Please complete the following - print or type information' section with a 'Print' button.
- A 'PLEASE CHECK ONE' section with radio buttons for 'CHECKING ACCOUNT' (selected) and 'SAVINGS ACCOUNT'.
- Fields for 'BANK TRANSIT NUMBER' (071000013) and 'DEPOSITOR'S ACCOUNT NUMBER' (45565456).
- A checkbox 'I HAVE READ AND ACCEPT THE ABOVE AGREEMENT' which is checked.
- A 'DEPOSITOR'S SIGNATURE' field with a red asterisk and 'Click here to sign' text.
- A 'DATE' field with '07/21/2017' and a 'RELATIONSHIP TO APPLICANT' field.
- A 'DIRECT BILLING' section.
- A 'FIRST MONTH PREMIUM AMOUNT OF \$' field.
- A 'SEND ME A PAPER COPY' checkbox.

At the bottom, there's a 'Saved' status and a page indicator '5 / 8'.

Lastly, proceed to “Section G” (page 7) to e-sign your name. And then select “Click to Sign” at the bottom of the page.

Agreement: I acknowledge receipt of the required Certificate of Coverage and I agree that insurance coverage is intended to be paid as my primary insurer and that this policy is offered on my representation that only I, a family member, or permissible third party as outlined below will pay BCBSIL directly. I understand that BCBSIL does not accept payments of premiums or cost-sharing payments directly from third parties except from those identified in Section D (family members, Required Entities, certain private non-profit foundations). I understand that a violation of this policy may result in premium and cost-sharing payments paid by a third party not being credited to my account or coverage or being refunded to me, which may result in the retroactive termination or cancellation of my coverage.

Special Enrollment Period Attestation and Acknowledgment. I understand that if I am applying for coverage outside of Open Enrollment, I must qualify for a Special Enrollment Period (SEP). I understand that in order to qualify for a SEP I must have experienced one of the qualifying events identified on page 1 of the application during the last 60 days, and I must provide acceptable proof of any qualifying event(s) with this application in order for BCBSIL to verify my eligibility.

I represent that the proof I am providing is valid and I understand that failure to provide proof of a qualifying event will delay or prevent the processing of my application and enrollment in coverage.

In addition I acknowledge that this coverage is intended to be individual coverage and nothing in this document creates a group health plan as defined under state and federal laws.

Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

PRIMARY APPLICANT'S SIGNATURE <i>[Handwritten Signature]</i>	DATE
SPOUSE'S SIGNATURE (IF APPLYING)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
DEPENDENT'S SIGNATURE (ONLY IF 18 OR OVER AND TO BE INSURED)	DATE
PARENT OR LEGAL GUARDIAN OF A MINOR CHILD	DATE
IF THIS AUTHORIZATION IS SIGNED BY A PERSONAL REPRESENTATIVE ON BEHALF OF AN INDIVIDUAL (OTHER THAN A PARENT FOR A MINOR CHILD), COMPLETE THE FOLLOWING:	
PERSONAL REPRESENTATIVE'S NAME (PLEASE PRINT)	RELATIONSHIP:

I agree to the Terms of Use and Consumer Disclosure of this document

[Click to Sign](#)

After signing Section G. Click “Submit to Agent”.

[Submit to Agent ✓](#)

After clicking Submit to Agent button, your application will be submitted for processing. Please allow 5 to 7 business days for processing and an additional 7 days for receiving your ID Card from Blue Cross Blue Shield of Illinois.