



MEDICAL & DENTAL HMO PROVIDER SELECTION FORM

As a new enrollee in HMO Illinois and/or Guardian/First Commonwealth DHMO you should complete this form to select a Primary Care Physician/Primary Dentist. The form does not replace your on-line enrollment selection.

HMO Illinois: A list of Primary Care Physicians can be found at <http://www.bcbsil.com/providers/index.html> select "Search by Health Plan" and enter HMO Illinois as your health plan.

Guardian/First Commonwealth: A list of Primary Dentists can be found at <http://www.firstcommonwealth.net> click "Provider Directory."

PERSONAL INFORMATION		(<input type="checkbox"/> APPLY) HMO ILLINOIS ENROLLMENT INFORMATION	(<input type="checkbox"/> APPLY) GUARDIAN/FIRST COMMONWEALTH ENROLLMENT INFORMATION
Employee Last Name:	First Name:	PCP Name:	Primary Dentist Name:
		PCP #:	
Employer Name:	Phone Number:	Group /IPA:	PCDID #:
LOYOLA UNIVERSITY CHICAGO		H.R. USE ONLY	
Date of Birth:	Last 4 Digits of Soc:	Group Number:	Group Number:
		Section Number:	Section Number:
DEPENDENT'S INFORMATION			
DEPENDENT 1:		HMO ILLINOIS	GUARDIAN/ FIRST COMMONWEALTH
Dependent Last Name:	First Name:	PCP Name:	Primary Dentist Name:
Date of Birth:	Relationship to you:	PCP #:	PCDID #:
		GROUP/IPA:	
DEPENDENT 2:		HMO ILLINOIS	GUARDIAN/ FIRST COMMONWEALTH
Dependent Last Name:	First Name:	PCP Name:	Primary Dentist Name:
Date of Birth:	Relationship to you:	PCP #:	PCDID #:
		GROUP/IPA:	
DEPENDENT 3:		HMO ILLINOIS	GUARDIAN/ FIRST COMMONWEALTH
Dependent Last Name:	First Name:	PCP Name:	Primary Dentist Name:
Date of Birth:	Relationship to you:	PCP #:	PCDID #:
		GROUP/IPA:	
DEPENDENT 4:		HMO ILLINOIS	GUARDIAN/ FIRST COMMONWEALTH
Dependent Last Name:	First Name:	PCP Name:	Primary Dentist Name:
Date of Birth:	Relationship to you:	PCP #:	PCDID #:
		GROUP/IPA:	

Complete and fax this form to Human Resources at (312) 915-7612. If you have any questions, please feel free to call the HR Department at (312) 915-7514.

Employee's Signature: _____ Date: _____