



Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY

Policy/Group No. _____

Section No. _____

Effective Date _____

New Hire Waiting Period _____

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:
(To be completed by employer)

Insurer: _____ Insurer: _____ Insurer: _____
Insurer: _____ Insurer: _____ Insurer: _____

TO BE COMPLETED BY EMPLOYER

Employer Name: _____

Phone #: _____

Address: _____

Reason for Enrollment (Mark all that apply)

New Enrollment: New Group Open Enrollment New Hire (Date: _____) Late Enrollee

Special Enrollment: Adoption Court Order Dependent Addition Divorce Domestic Partner
 Loss of Coverage Marriage Newborn Other Date of Event: ____/____/____

Employment Status: Active Retiree (Retirement Date: ____/____/____)

Illinois Continuation COBRA

Employee Dependent

Qualifying Event: _____

Start Date ____/____/____ Projected End Date ____/____/____

A Employee Information

Name (Last) _____

(First) _____

(MI) _____

Job Title: _____

Hire Date: _____

Hrs/Week: _____

Marital Status: Married Single Divorced Widowed Domestic Partner

Home Address: _____

Apt #: _____

City: _____

State: _____

Zip: _____

Home (or Cell) Phone: () _____

Business Phone: () _____

Email Address (optional): _____

B Coverage Requested

Medical

Employee: Yes No

Spouse/Domestic Partner: Yes No

Child(ren): Yes No

Plan Choice: _____

Plan Choice: _____

Plan Choice: _____

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.



Employer Name _____ Employee Name _____

C Waiver of Coverage

Please complete this section only if you are waiving (declining) coverage for yourself or one or more of your family members.

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- ◆ If I am declining coverage for myself, my spouse/domestic partner, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse/domestic partner, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- ◆ If I have a new spouse/domestic partner or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse/domestic partner or child provided that I request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.
- ◆ If I decide to request coverage in the future, for a reason other than the termination of other coverage or the addition of a new spouse/domestic partner or child, I may be considered a late enrollee, if applicable, or I may have to wait until the plan’s next open enrollment period. I also understand that as a late enrollee, coverage for preexisting conditions may be excluded for up to a period of 18 months. This period may be offset by the time I, my spouse/domestic partner, or my dependent child(ren) was covered under a qualified health plan.

I certify that I was not pressured, forced, or unfairly induced by my employer, the agent, or the insurer(s) into waiving or declining the group coverage.

I **DO NOT** want, and hereby waive, coverage for (initial next to all that apply):

Medical for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Dental* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Vision* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Basic Life* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Dependent Life* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Voluntary Life* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Short-Term Disability* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)
Long-Term Disability* for	[]	Myself	[]	My Spouse/Domestic Partner	[]	My Dependent Child(ren)

* If offered.

I am **declining** group coverage for the following reason(s): (check all that apply)

- Spouse/Domestic Partner’s Employer Plan Individual Coverage (Non-Group Plan)
- COBRA/State Continuation Medicare or other Government Program
- Other (please explain): _____

⊛ If you are declining ALL coverage for ALL persons, please skip to the Acknowledgement & Signature section on page 10 of this application.



Employer Name _____ Employee Name _____

D Individuals Requesting Coverage

List yourself and all eligible family members to be included under coverage.

- ◆ Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy.
- ◆ Illinois' Young Adult Dependent Coverage law allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, regardless of whether the child may be considered a dependent for tax or other purposes. For more information, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Note: For purposes of this application, an “eligible military veteran” is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth: / /	
Weight: _____ lbs.	Height: _____ ft. in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
HMO only (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth: / /	
Weight: _____ lbs.	Height: _____ ft. in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
HMO only (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
Dependent Name (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth: / /	
Weight: _____ lbs.	Height: _____ ft. in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
HMO only (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
Dependent Name (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth: / /	
Weight: _____ lbs.	Height: _____ ft. in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
HMO only (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
Dependent Name (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth: / /	
Weight: _____ lbs.	Height: _____ ft. in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
HMO only (if/when applicable): Primary Care Physician: _____		Physician ID: _____	



Employer Name _____ Employee Name _____

Dependent Name (Last) _____ (First) _____ (MI) _____	
Social Security Number: _____	Date of Birth: / /
Weight: _____ lbs.	Height: _____ ft. in.
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	
HMO only (if/when applicable): Primary Care Physician: _____	Physician ID: _____

E Current/Prior Coverage Information

Please indicate for EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within **24 months** prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the **past 24 months**, please indicate **NONE**. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

Note: If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. You will be subject to an automatic PEC Waiting Period of up to 12 months until the insurer receives evidence of prior coverage.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) _____ (First) _____ (MI) _____	
▶ Current/Most Recent Coverage: <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ Prior Coverage (if any): <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____	
▶ Current/Most Recent Coverage: <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ Prior Coverage (if any): <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
Dependent Name (Last) _____ (First) _____ (MI) _____	
▶ Current/Most Recent Coverage: <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ Prior Coverage (if any): <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	



Employer Name _____ Employee Name _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** Group Medical Dental Individual Medical None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

▶ Will the individual continue this coverage? Yes No

▶ **Prior Coverage (if any):** Group Medical Dental Individual Medical None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** Group Medical Dental Individual Medical None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

▶ Will the individual continue this coverage? Yes No

▶ **Prior Coverage (if any):** Group Medical Dental Individual Medical None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage:** Group Medical Dental Individual Medical None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

▶ Will the individual continue this coverage? Yes No

▶ **Prior Coverage (if any):** Group Medical Dental Individual Medical None
 Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____
 Policyholder Name: _____ Insurer Name: _____

Medicare: If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name (Last) _____ (First) _____ (MI) _____

Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D Effective Date: _____/_____/_____ Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ERSD <input type="checkbox"/> Dual Enrollment	Medicare Number (please include alpha prefix):
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Enrolling Individual Name (Last) _____ (First) _____ (MI) _____

Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D Effective Date: _____/_____/_____ Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ERSD <input type="checkbox"/> Dual Enrollment	Medicare Number (please include alpha prefix):
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Employer Name _____ Employee Name _____

F Health Statement**Instructions:**

1. The information you provide in this application is confidential. You should discuss with your employer if you prefer to submit the completed health statement directly to the insurance company or insurance broker.
2. The health information you provide below will be used by the insurance company to determine the price to charge your group for the coverage applied for and whether a Pre-Existing Condition Waiting Period(s) will apply to your coverage. Coverage for pre-existing conditions cannot be limited or excluded for dependents under the age of 19.
3. Each medical question below applies to all persons requesting coverage.
4. Answer the questions below with either Yes or No. If you answer Yes to any question, you must provide additional information in Section G below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or may authorize you to provide anything less than a complete and accurate response to each of the questions.
7. After you submit this application, the insurance company may call you to obtain additional confidential information needed to evaluate and aid the processing of your application.

1 For the following conditions, **within the past 5 years**, have you or any dependents for whom you are requesting coverage:

- Been tested for or diagnosed with;
- Had medical treatment recommended;
- Received medical treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition related to any of the categories listed below?

A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
B. Cancer or cancerous tumor?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
D. Diabetes? If yes, check all that apply: <input type="checkbox"/> Non-Insulin Dependent <input type="checkbox"/> Insulin Dependent <input type="checkbox"/> Insulin Pump	<input type="checkbox"/> Yes	<input type="checkbox"/> No
E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
F. Growth disorder or a disorder of the pancreas?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
H. Reproductive organ disorders or infertility?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
I. Arthritis, or any other disorder of the joints, muscles, back, or bones?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
J. Mental or emotional disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No



Employer Name _____ Employee Name _____

L. HIV positive, AIDS, diseases associated with AIDS, lupus, or other disorder of the immune system?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
M. Alcohol, drug, or substance use or dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
N. Organ or bone marrow transplant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2 Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant? Due Date: ____/____/____ (MM/DD/YYYY) If yes, are multiples (twins, triplets, etc.) expected? Are there any known complications, or is a cesarean section planned?	<input type="checkbox"/> Yes <input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No <input type="checkbox"/> No
3 Within the past 12 months, have you or your spouse/domestic partner used any tobacco products? Employee: Spouse/Domestic Partner:	<input type="checkbox"/> Yes <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> No
4 Within the past 12 months, has any applicant been prescribed medication (other than for the common cold or flu) that is not indicated elsewhere in this application ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5 Within the past 5 years, has any person applying for coverage been tested for or diagnosed with, had medical treatment recommended, received medical treatment, including prescription medications, or been hospitalized for any illness, injury or health condition not indicated above ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

G Additional InformationIf you answered "Yes" to any of the questions above, you must complete this section.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No



Employer Name _____ Employee Name _____

Question Number: _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No**Question Number:** _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No**Question Number:** _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No**Question Number:** _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No**Question Number:** _____ **Name of Individual:** _____

Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____

Treatment Received: _____

Treatment ongoing? Yes No Last Treatment Date: _____

Surgery, additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? Yes No



Employer Name _____ Employee Name _____

H Additional Coverage Options

You should complete this section only if your employer offers any of the additional coverage options below.

Employee▶ Dental: PPO HMO

Dental HMO Office ID # (if applicable): _____

 Vision Basic Life Dependent Life Voluntary Life: Amount (if applicable): \$ _____ Short-Term Disability Long-Term Disability▶ **Employee Class** (employer will provide you with this information if needed): _____▶ **Salary** (if requesting life or disability coverage): \$ _____ Hourly Weekly Monthly Semi-monthly Annually**Spouse/Domestic Partner**▶ Dental: PPO HMO

Dental HMO Office ID # (if applicable): _____

 Vision Basic Life Dependent Life Voluntary Life: Amount (if applicable): \$ _____ Short-Term Disability Long-Term Disability**Child(ren)**▶ Dental: PPO HMO

Dental HMO Office ID # (if applicable): _____

 Vision Basic Life Dependent Life Voluntary Life: Amount (if applicable): \$ _____ Short-Term Disability Long-Term Disability**Beneficiary Information** (if requesting life insurance)

Primary Beneficiary Name (Last, First, MI) _____

Relationship _____ Benefit % _____

Secondary Beneficiary Name (Last, First, MI) _____

Relationship _____ Benefit % _____



Employer Name _____ Employee Name _____

I Acknowledgement & Signature

I understand, agree, and represent that:

- ◆ I have read this document or it has been read to me.
- ◆ The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- ◆ Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- ◆ I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- ◆ If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature _____ Date _____

- ☛ For assistance in completing this application, please contact your employer or insurance agent.
For information about your health care rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.