Illinois Department of Insurance

PAT QUINN
Governor

MICHAEL T. McRAITH
Director

TO: ALL ILLINOIS INSURANCE PRODUCERS AND ALL CARRIERS OFFERING HEALTH COVERAGE SUBJECT TO 215 ILCS 5/359b

FROM: MICHAEL T. MCRAITH MTM

DATE: DECEMBER 13, 2010

RE: COMPANY BULLETIN 2010-10
STANDARD HEALTH APPLICATIONS

Section 359b of the Illinois Insurance Code (215 ILCS 5/359b) requires all carriers offering health benefit plans in the small group market and all carriers offering individual health insurance coverage in the individual market to use standard health applications beginning January 1, 2011. Pursuant to Section 359b, the Department established a Health Application Working Group to develop two standard health applications: one for use in the individual market, and a standard employee application for use in the small group market. Final versions of the standard applications, as adopted by the Working Group, are attached as Exhibits A and B.

Through this bulletin and accompanying exhibits, the Department provides guidance to carriers on how to comply with the requirements of Section 359b relating to the use of standard health applications. The Department's objective is to allow sufficient time for carriers and insurance producers to prepare for the statute's January 1 effective date, and to ensure individuals and small employers in Illinois receive the full benefits of the standard health applications.

A standard health application submitted in accordance with the Filing Directions outlined in Exhibit D, and accompanied by a properly completed and executed Certification of Compliance (Exhibit C), will be accepted by the Department as satisfying all applicable laws and regulations governing health insurance applications, and will be approved in an expedited manner. This does not preclude subsequent Department action should the certification have been made in error or if the application does not otherwise meet the standards established in this bulletin and accompanying exhibits. If a problem is discovered within a filing after its submission, the certification will not be valid and the filing must then be withdrawn and resubmitted in order to ensure it conforms with Department requirements.

The Department has proposed a rule providing additional guidance for the use of the standard health applications by carriers and insurance producers. *See* 34 Ill. Reg. 15708 (proposed October 15, 2010). Until the proposed rule is adopted, carriers using a standard health application as outlined in this bulletin will be deemed in compliance with the requirements of Section 359b. The certification and approval process outlined in this bulletin will terminate upon adoption of the proposed rule, and will be replaced by the procedures and standards contained therein. The Department will not require standard applications filed and approved pursuant to this bulletin to be re-filed after the proposed rule is adopted, unless otherwise required by the rule.

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Springfield, IL 62767
(217) 782-4515
insurance.illinois.gov

The Department recognizes that some Illinois families and businesses may wish to submit a carrier-specific (non-standard) health insurance application that was obtained prior to the statute's January 1, 2011 effective date. Therefore, until February 1, 2011, a carrier subject to the requirements of Section 359b shall accept both a standard health application approved pursuant to this bulletin, and the carrier's current (non-standard) application form. During this 30-day transition period, carriers may not market or distribute any applications other than standard applications approved pursuant to this bulletin.

Questions regarding this bulletin should be directed to Cindy Colonius at Cindy.Colonius@illinois.gov.

Enclosed:
Exhibit A – Illinois Standard Health Employee Application for Small Employers
Exhibit B – Illinois Standard Health Application for Individual & Family Health Insurance Coverage
Exhibit C – Certification of Compliance
Exhibit D – Filing Directions

Illinois Standard Health Application for Individual & Family Health Insurance Coverage

For assistance in completing this application, please contact your insurance agent or the insurance company directly. 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.

INSTRUCTIONS:

1. Any information you provide in this application is confidential.
2. The answers you provide in this application must be true and complete, to the best of your knowledge and belief. Do not leave any question unmarked.
3. An intentional misrepresentation may result in your policy being modified or terminated, or in claims being reduced or denied.
4. [For online version only] You should have the following information available, for each person requesting coverage:
   - Social Security Number, date of birth, and height/weight;
   - Information about any current or prior insurance coverage in effect within the last 12 months; and
   - Personal health information. If you do not have enough information to respond to a question, you should obtain any required information from your current or former health care provider(s).
5. For purposes of this application, the term "dependent" refers to any child up to age 26 (or age 30 for military veterans) for whom you are requesting coverage, regardless of whether the child may be considered a dependent for tax or other purposes. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to age 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

A Primary Applicant Information

Name (Last)	(First)	(MI)
Residential Street Address:		Apt #:
City:	State:	Zip:
Mailing Address (if different):		Apt #:
City:	State:	Zip:
Primary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Secondary Phone Number: ( )	Best time to call: ☐ Morning ☐ Afternoon ☐ Evening	
Email Address (optional):		
Please check one of the following boxes: ☐ New Application ☐ Dependent Addition ☐ Plan Change ☐ Reinstatement		
Requested Effective Date: _____ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)		

B Employment Information

Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:
Currently employed? (optional) Self: ☐ Yes ☐ No Spouse/Domestic Partner: ☐ Yes ☐ No	

PRIMARY APPLICANT NAME ____________________ DATE ____________

C Persons Requesting Coverage

List all family members you wish to include under the policy. Insurance companies may have different rules about who may qualify as an eligible dependent. For more information regarding the available coverage, please check with your insurance agent or insurance carrier.

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.

Self Name (Last) ____________ (First) ____________ (MI) ____

Social Security Number (for internal use only): | Date of Birth: / /

State of Birth (country if born outside the U.S.): | Gender: ☐ Male ☐ Female

Percentage of time annually spent outside of Illinois for residence, work, or school:

Spouse/Domestic Partner Name (Last) ____________ (First) ____________ (MI) ____

Social Security Number (for internal use only): | Date of Birth: / /

State of Birth (country if born outside the U.S.): | Gender: ☐ Male ☐ Female

Percentage of time annually spent outside of Illinois for residence, work, or school:

Dependent Name (Last) ____________ (First) ____________ (MI) ____

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

Dependent Name (Last) ____________ (First) ____________ (MI) ____

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

Dependent Name (Last) ____________ (First) ____________ (MI) ____

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

PRIMARY APPLICANT NAME _____ DATE _____

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

Relationship to Applicant: | Date of Birth: / /

Social Security Number (for internal use only): | Gender: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ No

Percentage of time annually spent outside of Illinois for residence, work, or school:

D Current/Prior Coverage Information

For EACH person listed on this application, please indicate any public health insurance coverage (for example, Medicare, HFS Medical Card, All Kids, Family Care, or other federal and state programs) or private health insurance in effect within the **last 12 months**. Each person applying for insurance must be listed below. If health insurance coverage was not in effect within the **last 12 months**, please indicate **NONE.**

Self Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

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

▶ **Current/Most Recent Coverage**:
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____
▶ Is the issuance of this coverage **replacing** your existing coverage?* ☐ Yes ☐ No

▶ **Prior Coverage (if any):**
☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: _____ _____)
▶ **Dates of Coverage**: From: _____/_____/_____ To: _____/_____/_____

PRIMARY APPLICANT NAME ________________________ DATE ______________

Dependent Name (Last) ______________ (First) ______________ (MI) ____

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

Dependent Name (Last) ______________ (First) ______________ (MI) ____

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

Dependent Name (Last) ______________ (First) ______________ (MI) ____

▶ **Current/Most Recent Coverage**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

▶ Is the issuance of this coverage **replacing** your existing coverage?✶ ☐ Yes ☐ No

▶ **Prior Coverage (if any)**:

☐ None ☐ Medicare ☐ Other Public ☐ Private (Insurer: ______________________)

▶ **Dates of Coverage**: From: ____/____/____ To: ____/____/____

✶ If answering "YES" please carefully read the following notice.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT & HEALTH INSURANCE

According to information you have furnished, you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by the insurance carrier. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the insurance carrier to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.
4. It is recommended that you do not terminate your present contract until you are certain that your application for the new contract has been approved by the insurance carrier.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

E Health Statement

The federal **Genetic Information Nondiscrimination Act** prohibits health insurers from asking for and using **"genetic information"** when deciding whether to offer coverage and how much to charge for coverage. For more information on the Genetic Information Nondiscrimination Act, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Instructions:

1. Each medical question below applies to each person requesting coverage.
2. Answer the questions below by checking Yes or No. If you answer Yes to any question, you must provide additional information in Section F below.
3. Do not leave any question unmarked.

Limited Privacy Available: Persons age 18 or older may submit a signed and dated separate health statement. The information provided in such separate health statement(s) will likely be disclosed to the primary applicant.

1 For any of the following conditions, **within the past FIVE (5) years**, has anyone applying for coverage:

- Been diagnosed with;
- Had treatment or testing recommended;
- Received treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition listed below?

If answering "YES," check all that apply.

A. **Heart/Circulatory Conditions/Disorders:** ☐ Yes ☐ No

▶ **Heart:** ☐ Heart attack ☐ Chest pain ☐ Heart murmur ☐ Irregular heartbeat
☐ High/elevated blood pressure* ☐ High/elevated cholesterol*
✶ If applicable, please provide last known blood pressure or cholesterol reading in Section F.

▶ **Circulatory:** ☐ Anemia ☐ Bleeding/clotting disorder ☐ Varicose/spider veins ☐ Phlebitis

B. **Lymphatic Conditions/Disorders:** ☐ Yes ☐ No

☐ Lymphadenopathy ☐ Enlarged lymph nodes ☐ Disease of the spleen

C. **Cancer/Tumors/Growths:** ☐ Yes ☐ No

☐ Cancer ☐ Tumors ☐ Cysts ☐ Polyps ☐ Lumps ☐ Other abnormal growths

D. **Respiratory Conditions/Disorders:** ☐ Yes ☐ No

☐ Asthma ☐ Bronchitis ☐ Emphysema ☐ Sleep apnea ☐ Pneumonia ☐ Tuberculosis
☐ Chronic obstructive pulmonary disease (COPD)

E. **Intestinal/Digestive Conditions/Disorders:** ☐ Yes ☐ No

☐ Acid reflux ☐ Ulcers ☐ Hernia *(indicate type)* ☐ Colitis ☐ Hemorrhoids ☐ Rectal bleeding ☐ Gallstones
☐ Irritable bowel syndrome ☐ Chronic diarrhea ☐ Hepatitis *(indicate type)* ☐ Elevated liver function test
☐ Jaundice ☐ Cirrhosis ☐ Gallbladder infection or inflammation ☐ Pancreatitis ☐ Crohn's disease

F. **Urinary Conditions/Disorders:** ☐ Yes ☐ No

☐ Kidney infection ☐ Kidney stones ☐ Bladder infection ☐ Cystitis ☐ Urinary reflux ☐ Urinary tract infection

G. **Metabolic/Endocrine Conditions/Disorders:** ☐ Yes ☐ No

☐ Diabetes ☐ Thyroid disorder ☐ High/low blood sugar ☐ Adrenal, pituitary, or other glandular disorder
☐ Chronic fatigue syndrome ☐ Obesity/weight loss surgery

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

H. Brain/Nervous System Conditions/Disorders: ☐ Yes ☐ No

☐ Seizures ☐ Migraine headaches/Chronic severe headaches ☐ Head injury ☐ Paralysis ☐ Epilepsy ☐ Tremor
☐ Stroke or TIA ☐ Multiple sclerosis ☐ Parkinson's ☐ Restless leg syndrome ☐ Lou Gehrig's disease (ALS)

I. Immune System Conditions/Disorders: ☐ Yes ☐ No

☐ HIV positive ☐ AIDS ☐ Diseases associated with AIDS

J. Musculoskeletal Conditions/Disorders: ☐ Yes ☐ No

☐ Arthritis ☐ Gout ☐ Lupus ☐ Herniated disc ☐ Temporomandibular joint disorder (TMJ)
☐ Carpal tunnel syndrome ☐ Disease/disorder of the back or spine ☐ Other bone or joint disorder

K. Mental/Behavioral/Emotional Conditions/Disorders: ☐ Yes ☐ No

☐ Depression ☐ Anxiety disorder ☐ Attention deficit disorder ☐ Chemical imbalance ☐ Bi-polar disorder
☐ Obsessive compulsive disorder ☐ Eating disorder

L. Allergies: ☐ Yes ☐ No

☐ Allergies in any form ☐ Hay fever ☐ Hives ☐ Anaphylaxis

M. Eye Conditions/Disorders: ☐ Yes ☐ No

☐ Glaucoma ☐ Cataracts ☐ Strabismus (crossed eyes) ☐ Detached retina

N. Ear Conditions/Disorders: ☐ Yes ☐ No

☐ Hearing disorder ☐ Ear infection ☐ Loss of hearing

O. Nasal Conditions/Disorders: ☐ Yes ☐ No

☐ Deviated septum ☐ Adenoiditis ☐ Sinusitis

P. Throat Conditions/Disorders: ☐ Yes ☐ No

☐ Tonsillitis ☐ Strep throat

Q. Skin Conditions/Disorders: ☐ Yes ☐ No

☐ Acne ☐ Psoriasis ☐ Eczema ☐ Keratosis ☐ Pre-cancerous lesions ☐ Herpes ☐ Melanoma

R. Congenital Abnormalities/Developmental Disorders: ☐ Yes ☐ No

- **Congenital Abnormality:** ☐ Cleft palate/lip ☐ Club foot ☐ Heart/lung/kidney defect or malformation
- **Developmental Disorder:** ☐ Pervasive development disorder ☐ Down's syndrome ☐ Autism spectrum disorder ☐ Learning disability

S. Reproductive System Conditions/Disorders: ☐ Yes ☐ No

- **Female:** ☐ Infertility ☐ Abnormal menstrual bleeding ☐ Abnormal PAP smear ☐ Endometriosis ☐ Ovarian cyst ☐ Sexually transmitted disease ☐ Human papillomavirus (HPV) ☐ Pregnancy complications ☐ Uterine fibroid ☐ Breast infection or inflammation
- Is any female applicant currently pregnant, an expectant parent, or in the process of adopting? ☐ Yes ☐ No
- **Male:** ☐ Infertility ☐ Erectile dysfunction ☐ Sexually transmitted disease ☐ Prostate disorder ☐ Gynecomastia
- Is any male applicant an expectant parent or in the process of adopting? ☐ Yes ☐ No

T. Other Conditions: ☐ Yes ☐ No

Within the **past 5 years**, has anyone applying for coverage been diagnosed with, had treatment or testing recommended, received treatment, including prescription medications, or been hospitalized for **any illness, injury, or health condition not indicated elsewhere in this application?**

Note: You must include any illness, injury, or health condition related to one of the categories above, even if your specific illness, injury, or condition is not listed above.

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

Within the past FIVE (5) YEARS:		
2 Has anyone applying for coverage received treatment or had treatment recommended for drug or alcohol abuse, or been convicted of a drug or alcohol related offense (including a DUI)?	☐ Yes	☐ No
3 **Other than indicated elsewhere on this application**, has anyone applying for coverage had an implant (e.g., breast, chin, or penile implant), internal fixation (e.g., pins, plates, rods, screws), prosthesis, pacemaker, heart valve replacement, shunt, or monitoring device?	☐ Yes	☐ No
4 Has anyone applying for coverage had testing performed and are currently **waiting for results**, or been advised to have treatment, testing, counseling, therapy, or surgery which has **not yet been performed**?	☐ Yes	☐ No

Within the past TWELVE (12) MONTHS:		
5 Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	☐ Yes	☐ No
6 Has anyone applying for coverage used any tobacco product (such as cigarettes, snuff, chewing tobacco, or any nicotine substitution product)? ▶ If yes, indicate who: ☐ Primary Applicant ☐ Spouse/Domestic Partner ☐ Dependent Children	☐ Yes	☐ No
7 Has anyone applying for coverage participated in any dangerous or extreme sport activities, including, but not limited to: organized automobile/motorcycle/powerboat racing, skydiving, bungee jumping, ultralight flying, scuba diving, hang gliding, or outdoor rock/mountain climbing?	☐ Yes	☐ No

If yes, indicate:

Who & Which Activity	When/How Often	Do you plan continued participation?
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No
_____		☐ Yes ☐ No

8 **Other than indicated elsewhere on this application**, has any person applying for coverage **EVER** been treated, hospitalized, or had surgery for:

- bypass? ☐ Yes ☐ No
- angioplasty? ☐ Yes ☐ No
- stent? ☐ Yes ☐ No
- aneurysm? ☐ Yes ☐ No
- valve replacement? ☐ Yes ☐ No
- cancer? ☐ Yes ☐ No
- stroke? ☐ Yes ☐ No
- congenital abnormality? ☐ Yes ☐ No
- organ or bone marrow transplant? ☐ Yes ☐ No

PRIMARY APPLICANT NAME _____ DATE _____

DEPENDENT NAME (If submitted separately) _____

9 For **EACH** person applying for coverage, complete the following information regarding his/her **last physical exam** (including checkups):

Self Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Spouse/Domestic Partner's Name: _____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

Dependent's Name:_____ Exam Date (MM/YY):_____/_____ Routine preventive care/wellness visit? ☐ Y ☐ N

10 For **EACH** person applying for coverage, provide the following <u>current</u> information regarding his/her **height and weight**:

Self Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Spouse/Domestic Partner's Name: _____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

Dependent's Name:_____ Height (Feet/Inches):_____/_____ Weight (in pounds): _____

F Additional Information

If you answered "YES" to any of the questions in Section E, you must provide additional information below. For an example of how to fill out this section, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Attach a separate sheet for additional information if necessary.

Question Number: _____ Name of Individual: _____

Condition/Diagnosis: _____

Treatment Received: _____

_____

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: _____

Additional tests or treatment recommended? _____

Medication Prescribed (if any): _____

_____ Currently taking medication? ☐ Yes ☐ No

Physician Name _____

Phone # (_____)_____ City & State _____

PRIMARY APPLICANT NAME ______________________ DATE ______________

DEPENDENT NAME (If submitted separately) ______________________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________

Additional tests or treatment recommended? ______________________

Medication Prescribed (if any): ______________________________

______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________

Additional tests or treatment recommended? ______________________

Medication Prescribed (if any): ______________________________

______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________

Additional tests or treatment recommended? ______________________

Medication Prescribed (if any): ______________________________

______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________________

Question Number: _______ **Name of Individual:** ______________________________

Condition/Diagnosis: ______________________________

Treatment Received: ______________________________

Treatment ongoing? ☐ Yes ☐ No First & Last Treatment Date: ______________________

Additional tests or treatment recommended? ______________________

Medication Prescribed (if any): ______________________________

______________________ Currently taking medication? ☐ Yes ☐ No

Physician Name ______________________________

Phone # (________)______________ City & State ______________________

PRIMARY APPLICANT NAME ______________________ DATE ______________

DEPENDENT NAME (If submitted separately) ______________________________

G Prescription Information within the Last Twelve (12) Months

Within the past 12 months, has anyone applying for coverage been prescribed medication (other than for the common cold or flu) that is **not indicated elsewhere in this application**? ☐ Yes ☐ No

Attach a separate sheet for additional information if necessary.

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (_______)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (_______)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (_______)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (_______)________________ City & State ________________

Name of Individual: ______________________________

Name of Medication: ______________________________

Reason for Taking: ______________________________

First & Last Treatment Date: ____________________ Currently taking medication? ☐ Yes ☐ No

Physician Name: ______________________________

Phone # (_______)________________ City & State ________________

PRIMARY APPLICANT NAME _____ DATE _____

AFFIRMATION

Signature – Adult applicants must sign this form below. Parent or guardian signature is required for applicants under the age of 18. **By signing this form, you certify the following**:

1. I have read this entire application or it has been read to me.
2. No independent producer, agent, or employee of the insurer can change any part of this application or waive the requirement that I answer all questions completely and accurately.
3. 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.
4. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.** For more information, please visit the Illinois Department of Insurance's website at www.insurance.illinois.gov.

STATEMENT OF UNDERSTANDING

I understand and agree that:

- The information I have provided in this application will be used by the insurer to determine whether to extend coverage and the premium amount for such coverage.
- No coverage shall be in force until approved by the insurer. If approved, coverage will be in force as of the effective date determined by the insurer.
- This application will become part of the contract between the insurer and me.
- Except for a dependent up to the age of 19, coverage for preexisting medical conditions may be excluded or be subject to a waiting period of up to 24 months.
- I am entitled to a copy of this application and the Authorization to Use and Disclose Protected Health Information that is a part of this application upon request. I agree that a photographic copy shall be as valid as the original. A legible facsimile signature shall have the same force and effect as the original.
- I authorize the insurer to transmit the information contained herein electronically.

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I. Protected Health Information

By signing this form, I authorize certain organizations and persons to use or disclose my protected health information. Protected health information includes, but is not limited to, hospital records, physician records, claim or benefit records, lab results, mental health records, as well as information regarding the use of drug, alcohol, HIV/AIDS, sexually transmitted disease, and reproductive health services. Protected health information may be written, oral, or electronic. This form does not permit the use or disclosure of psychotherapy notes.

II. Purpose of this Authorization Form

By signing this form, I authorize the use and disclosure of protected health information for the purposes of pre-enrollment underwriting or risk-rating of health insurance coverage, to determine eligibility for enrollment or benefits under a health plan, or to allow the insurer to conduct utilization review and quality improvement activities ("Purpose").

III. Entities Authorized to Use and Disclose My Protected Health Information

Insurers: I hereby authorize the following insurers, their reinsurers, and their legal representatives ("Insurers") to receive, use, and disclose my protected health information for the Purpose listed above:

(Please list below the names of all the insurers to whom you are submitting this application).

Insurer: _____ Insurer: _____ Insurer: _____

Insurer: _____ Insurer: _____ Insurer: _____

PRIMARY APPLICANT NAME _____ DATE _____

I authorize the Insurers to disclose my protected health information: between themselves, to reinsuring companies, and to insurance intermediaries or other persons or organizations performing business or legal services in connection with the Purpose above.

I further authorize any licensed physician, medical practitioner, health care provider, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, or other organization, institution, or person that has any record or knowledge of my health to disclose such information to the extent permitted by law to Insurers for the Purpose above.

I understand that protected health information described in this form may be used by, or disclosed to or by, organizations and persons who are not subject to federal or state privacy laws.

IV. Term of Authorization

I agree this Authorization shall be valid for two-and-one-half (2 ½) years from the latest signature date below.

V. Right to Revoke

I understand I may revoke this authorization at any time by giving advance written notice to Insurers. Revocation of this authorization form will not affect actions Insurers and others took in reliance on this form prior to the written notice of revocation.

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.

I HAVE READ AND CONSIDERED THE CONTENTS OF THIS FORM. BY SIGNING THIS FORM, I HEREBY AUTHORIZE THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

_____Date _____
Primary Applicant (or Authorized Legal Representative) Signature

_____Date _____
Spouse / Domestic Partner Signature (ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

_____Date _____
Dependent Signature (ONLY if 18 or over and ONLY if to be insured)

✪ For assistance in completing this application, please contact your insurance agent or the insurance company directly. 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.

PRIMARY APPLICANT NAME _____ DATE _____

TO BE COMPLETED BY AGENT
I. Agent/Producer Information

I certify that:
1. All answers provided in this application were completed by or provided by the applicant.
2. I have reviewed this enrollment form to ensure that all required items have been completed.
3. I am not aware of any information not disclosed on this enrollment form relating to the health, habits, or reputation of any person listed on this enrollment form, which might have a bearing on the risk.

1. Producer/Writing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Producer Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

2. Agent/Managing Agent

Name:	ID#/Code:
Company:	Phone: ( )
Email:	
Agent Signature: Date Signed: (A faxed signature shall be valid as an original signature.)	

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: ☐ Male ☐ 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: ☐ Male ☐ 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: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ 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: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ 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: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ 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: ☐ Male ☐ Female

Eligible Military Veteran: ☐ Yes ☐ 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:** ☐ 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: _____

Spouse/Domestic Partner 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: _____

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 ☐ Part A ☐ Part B ☐ Part D
Effective Date: ________/________/________
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Medicare Number (please include alpha prefix):

Enrolling Individual Name (Last) __________________________ (First) __________________________ (MI) _______

Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: ________/________/________
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Medicare Number (please include alpha prefix):

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?	☐ Yes	☐ No
B. Cancer or cancerous tumor?	☐ Yes	☐ No
C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system?	☐ Yes	☐ No
D. Diabetes? If yes, check all that apply: □ Non-Insulin Dependent □ Insulin Dependent □ Insulin Pump	☐ Yes	☐ No
E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines?	☐ Yes	☐ No
F. Growth disorder or a disorder of the pancreas?	☐ Yes	☐ No
G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder?	☐ Yes	☐ No
H. Reproductive organ disorders or infertility?	☐ Yes	☐ No
I. Arthritis, or any other disorder of the joints, muscles, back, or bones?	☐ Yes	☐ No
J. Mental or emotional disorder?	☐ Yes	☐ No
K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system?	☐ Yes	☐ No

Employer Name _____ Employee Name _____

L. HIV positive, AIDS, diseases associated with AIDS, lupus, or other disorder of the immune system?	☐ Yes	☐ No
M. Alcohol, drug, or substance use or dependency?	☐ Yes	☐ No
N. Organ or bone marrow transplant?	☐ Yes	☐ No
2 Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant?	☐ Yes	☐ No
Due Date: _____/_____/_____ (MM/DD/YYYY)		
If yes, are multiples (twins, triplets, *etc.*) expected?	☐ Yes	☐ No
Are there any known complications, or is a cesarean section planned?	☐ Yes	☐ No
3 **Within the past 12 months,** have you or your spouse/domestic partner used any tobacco products? Employee:	☐ Yes	☐ No
Spouse/Domestic Partner:	☐ Yes	☐ 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?**	☐ Yes	☐ 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?**	☐ Yes	☐ No

G Additional Information

If you answered "Yes" to <u>any</u> 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.

Exhibit C

State of Illinois

Illinois Standard Health Application Certification of Compliance

Company: _____ Company FEIN: _____

Form Number(s): _____ Form Title(s):_____

I, _____, am a duly authorized officer of the above insurer, and do hereby certify that I am knowledgeable as to the current laws and regulations applicable to the policy form(s) identified above that are the subject of this filing (hereafter "the policy forms"), including Section 359b of the Illinois Insurance Code governing the use of standard applications, and that the policy forms are in compliance with such laws and regulations. I further certify that this submission is complete and contains all materials required by applicable laws and regulations.

I understand that the Illinois Department of Insurance will rely on this certification in approving the policy forms listed above, and should it subsequently be determined that the policy forms listed above do not comply with the applicable laws and regulations or that this certification is materially false or incorrect, corrective and disciplinary action, including retroactive disapproval, as authorized by law, may be taken by the Department against the company and the officer that completed this certification.

Signature of Corporate Officer: _____

Signature of Company Compliance Officer: _____

Name (typed or printed):_____

Title: _____ Direct Telephone Number: _____

Date: _____

(This certification does not change an insurer's responsibility to comply with the Insurance Code. Failure to comply with all applicable provisions of the Code will cause an insurer to be subject to penalties ranging from suspension of authority to utilize the expedited process, discontinuation of authority to use of the form(s), examination, monetary penalties, or limitation or revocation of their certificate of authority. Insurers should be aware that the assignment of such penalties will be liberal to ensure continued compliance with all Code requirements.)

Exhibit D – Filing Directions

Standard Health Applications

A. All versions of the standard health applications Exhibit A and Exhibit B must be filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916. These forms must be attached under the SERFF Form Schedule Section when filed through SERFF.

1. Filings for online versions of the standard health application must include screen shots of every application page that an applicant could encounter when completing the application online, as well as a copy of a sample completed application to be made available for printing or saving by the applicant after submission.

B. A standard health application must contain verbatim the text of Exhibit A or Exhibit B, and may not vary from the format of Exhibit A or Exhibit B, including with respect to font size, use of bold character and underlining, line spacing, and the order of questions or sections within the application, except that:

1. Online versions of the standard health applications may vary from the format of Exhibit A or Exhibit B to the extent such variation allows an applicant to more easily complete and submit the online application.

2. A standard health application may not contain logos, addresses, or other carrier-specific information or identifiers, except that the carrier's NAIC number must appear in the bottom right hand corner of each page.

3. Instruction #4 on page 1 of Exhibit B shall only be included in online versions of the standard health applications.

4. A carrier's name may be preprinted in one of the six designated spaces for carrier names on page 1 of Exhibit A or page 11 of Exhibit B.

5. The format of a standard health application filed pursuant to this Bulletin may vary from the format of Exhibit A or Exhibit B in other ways at the discretion of the Director.

C. Carriers may require applicants to complete, in addition to the standard health application, a separate administrative section as necessary to address plan selection, billing, and other carrier-specific needs related to the application and enrollment process. All such administrative sections must be filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916. Administrative sections must be filed under a separate form number from the standard health application(s), and must be attached under the SERFF Form Schedule Section when filed through SERFF.

1. Administrative sections may not contain questions that inquire about the health status or health history of any applicant.

2. Administrative sections may be attached to the front or back of a standard health application, but must constitute a separate and distinct section that may be detached from the standard health application. Administrative sections must contain carrier-specific

logos and addresses to distinguish those sections from the standard health applications.

3. An administrative section need not be filed with the Department under this Bulletin if the entire administrative section has been previously approved by the Department under a unique form filing number (and such approval remains in effect).

D. A filed application must be accompanied by a properly completed and executed officer's Certification of Compliance (Exhibit C). Exhibit C must be submitted under the SERFF Supporting Documentation Section when filed through SERFF.

1. For multiple company filings it is permissible to submit a single certification for all of the filings, but only if the company officer signing such certification has authority to sign on behalf of all of the companies, and if each company submits its own separate Form Number listing indicated on the Certification.

E. Once a filing has been received by the Department it is added to our system. This system produces a postcard that is sent to the company verifying that the filing has been received. In addition, SERFF filings will be designated as "Certification Received" in the State Status box in the SERFF filing.

F. Any filings submitted by CD-ROM must be mailed to the Department's Springfield address for processing:

Illinois Department of Insurance
LAH Compliance Section
320 W. Washington
Springfield, IL 62767

G. Companies currently change filings frequently after they are submitted to the Department. This practice will not be allowed under this certification process. No changes may be made to a filing. If a problem has been discovered within a filing after a submission, the certification is not valid and the filing must be withdrawn and resubmitted in order to confirm compliance with the Department's certification requirements.