



ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE

INSTRUCTIONS:

1. Any information provided in this application is confidential.
2. The answers provided within 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, back to your original effective date, or in claims being reduced or denied.
4. 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 24 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.

A. 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. PERSONS REQUESTING COVERAGE (attach separate sheet if necessary)

In the section below, 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. If you would like more information, please check with your insurance agent or insurance carrier. For information about Illinois’ Young Adult Dependent Coverage law, which allows parents to cover children up to the age of 26, and up to age 30 for military veterans, please visit the Illinois Department of Insurance website at <http://www.insurance.illinois.gov>.

SELF Name (Last, First, MI): _____ Social Security # (internal use only): _____ Gender (M/F) : _____ Date of Birth (MM/DD/YYYY): _____ State of Birth (Country if born outside the U.S.) _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____
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APPLICANT NAME _____ DATE _____

SPOUSE / DOMESTIC PARTNER Name (Last, First, MI): _____ Social Security # (internal use only): _____ Gender (M/F) : _____ Date of Birth (MM/DD/YYYY): _____ State of Birth (Country if born outside the U.S.) _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	
Name (Last, First, MI): _____ Relationship to Applicant: _____ Gender (M/F) : _____ Social Security # (internal use only): _____ Date of Birth (MM/DD/YYYY): _____ Percentage of time annually spent outside of Illinois for residence, work or school: _____	

C. EMPLOYMENT INFORMATION

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



APPLICANT NAME _____ DATE _____

D. CURRENT/PRIOR COVERAGE INFORMATION

Please indicate for EACH person listed on this application, 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 24 months. Each person applying for insurance must be listed below. If no health insurance coverage was in effect within the last 24 months, please indicate **NONE**.

Individual's Name:	Type of Coverage	Date of Coverage MM/DD/YYYY		Is the issuance of this coverage replacing your existing coverage?*
		From	To	
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Medicare <input type="checkbox"/> Other Public <input type="checkbox"/> Private (Insurer: _____) <input type="checkbox"/> None			<input type="checkbox"/> Yes <input type="checkbox"/> No

* 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.



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 <http://www.insurance.illinois.gov>.

INSTRUCTIONS:

1. Each medical question below applies to all persons requesting coverage.
2. Answer the questions below with either 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 separate health statement, which must be signed and dated. However, please keep in mind that the information provided in such separate health statement(s) may be disclosed to the primary applicant in certain circumstances.

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,” circle all that apply.

EXAMPLE:

Heart Condition: Heart attack, Chest pain, Heart Murmur, Irregular Heartbeat, High/Elevated Cholesterol, or High/Elevated Blood Pressure?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
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1a.	Heart/Circulatory conditions/disorders: Heart: Heart attack, chest pain, heart murmur, irregular heartbeat, high/elevated blood pressure*, or high/elevated cholesterol*? <i>*If applicable, please provide last known blood pressure or cholesterol reading in Section F.</i> Circulatory: Anemia, bleeding/clotting disorder, varicose/spider veins, or phlebitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1b.	Lymphatic conditions/disorders: Lymphadenopathy, enlarged lymph nodes, or disease of the spleen?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1c.	Cancer/Tumors/Growths: Cancer, tumors, cysts, polyps, lumps, or other abnormal growths?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1d.	Respiratory conditions/disorders: Asthma, bronchitis, emphysema, sleep apnea, pneumonia, tuberculosis, or chronic obstructive pulmonary disease (COPD)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1e.	Intestinal/Digestive conditions/disorders: Acid reflux, ulcers, hernia (<i>indicate type</i>), colitis, hemorrhoids, rectal bleeding, irritable bowel syndrome, chronic diarrhea, hepatitis (<i>indicate type</i>), elevated liver function test, jaundice, cirrhosis, gallstones, gallbladder infection or inflammation, pancreatitis, or Crohn’s disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No

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DEPENDENT NAME (if submitted separately) _____

1f.	Urinary conditions/disorders: Kidney infection, kidney stones, bladder infection, cystitis, urinary reflux, or urinary tract infection (UTI)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1g.	Metabolic/Endocrine conditions/disorders: Diabetes, thyroid disorder, high/low blood sugar, adrenal, pituitary or other glandular disorder, chronic fatigue syndrome, or obesity/weight loss surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1h.	Brain/Nervous System conditions/disorders: Seizures, migraine headaches or chronic severe headaches, head injury, paralysis, epilepsy, tremor, stroke or TIA, multiple sclerosis, Parkinson's, restless leg syndrome, or Lou Gehrig's disease (ALS)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1i.	Immune System conditions/disorders: HIV positive, AIDS, or diseases associated with AIDS?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1j.	Musculoskeletal conditions/disorders: Arthritis, gout, lupus, herniated disc, temporomandibular joint disorder (TMJ), carpal tunnel syndrome, disease/disorder of the back or spine, or other bone or joint disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1k.	Mental/Behavior/Emotional conditions/disorders: Depression, anxiety disorder, attention deficit disorder, chemical imbalance, bi-polar disorder, obsessive compulsive disorder, or eating disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1l.	Allergies: Allergies in any form, hay fever, hives, or anaphylaxis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1m.	Eye conditions/disorders: Glaucoma, cataracts, strabismus (crossed eyes), or detached retina?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1n.	Ear conditions/disorders: Hearing disorder, ear infection, or loss of hearing?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1o.	Nasal conditions/disorders: Deviated septum, adenoiditis or sinusitis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1p.	Throat conditions/disorders: Tonsillitis or strep throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1q.	Skin conditions/disorders: Acne, psoriasis, eczema, keratosis, pre-cancerous lesions, herpes, or melanoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1r.	Congenital Abnormalities/Developmental Disorders: Congenital Abnormality: Cleft palate/lip, club foot, or heart/lung/kidney defect or malformation? Developmental disorder: Pervasive development disorder, Down's syndrome, autism spectrum disorder, or learning disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
1s.	Reproductive System conditions/disorders: 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? Male: Infertility, erectile dysfunction, sexually transmitted disease, prostate disorder, or gynecomastia? Is any male applicant an expectant parent or in the process of adopting?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No

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APPLICANT NAME _____ DATE _____

DEPENDENT NAME (if submitted separately) _____

1t.	<p>Other Conditions: 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?</p> <p>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.</p>	<input type="checkbox"/> Yes <input type="checkbox"/> No
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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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Other than indicated elsewhere on this application , has anyone applying for coverage had an implant (<i>e.g.</i> , breast, chin or penile implant, etc.), internal fixation (<i>e.g.</i> , pins, plates, rods, screws, etc.), prosthesis, pacemaker, heart valve replacement, shunt or monitoring device?	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No

WITHIN THE PAST TWELVE (12) MONTHS:														
5.	Has anyone applying for coverage experienced unexpected weight gain or loss of more than 20 pounds?	<input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Primary applicant <input type="checkbox"/> Spouse/Domestic partner <input type="checkbox"/> Dependent children	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No												
	If yes, indicate: <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 35%; border-bottom: 1px solid black;">Who & Which Activity</td> <td style="width: 35%; border-bottom: 1px solid black;">When/How Often</td> <td style="width: 30%; text-align: right;">Do you plan continued participation?</td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> <tr> <td style="border-bottom: 1px solid black;"></td> <td style="border-bottom: 1px solid black;"></td> <td style="text-align: right;"> <input type="checkbox"/> Yes <input type="checkbox"/> No </td> </tr> </table>	Who & Which Activity	When/How Often	Do you plan continued participation?			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Yes <input type="checkbox"/> No	
Who & Which Activity	When/How Often	Do you plan continued participation?												
		<input type="checkbox"/> Yes <input type="checkbox"/> No												
		<input type="checkbox"/> Yes <input type="checkbox"/> No												
		<input type="checkbox"/> Yes <input type="checkbox"/> No												



APPLICANT NAME _____ DATE _____

DEPENDENT NAME (if submitted separately) _____

8.	<p>Other than indicated elsewhere on this application, has any person applying for coverage <u>EVER</u> been treated, hospitalized, or had surgery for:</p> <ul style="list-style-type: none"> ● bypass; ● angioplasty; ● stent; ● aneurysm; ● valve replacement; ● cancer; ● stroke; ● congenital abnormality; or ● organ transplant? 	<input type="checkbox"/> Yes <input type="checkbox"/> No
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9. For **EACH** person applying for coverage, complete the following information regarding their **last physical exam** (including checkups):

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

Person's Name: _____ Exam Date (MM/YYYY): ____/____/____ Routine preventive care/wellness visit? Y / N

10. For **EACH** person applying for coverage, complete the following information regarding their **height and weight**:

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

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

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

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

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

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

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

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



APPLICANT NAME _____ DATE _____

DEPENDENT NAME (if submitted separately) _____

F. ADDITIONAL INFORMATION (continued) (Attach a separate sheet for additional information if necessary)

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 <http://www.insurance.illinois.gov>.

Question Number: _____ Name of Individual: _____ Condition/Diagnosis: _____ Treatment Received: _____ _____ Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No First & Last Treatment Date: _____ Additional tests or treatment recommended? _____ Medication prescribed (if any): _____ _____ _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____
Question Number: _____ Name of Individual: _____ Condition/Diagnosis: _____ Treatment Received: _____ _____ Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No First & Last Treatment Date: _____ Additional tests or treatment recommended? _____ Medication prescribed (if any): _____ _____ _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____
Question Number: _____ Name of Individual: _____ Condition/Diagnosis: _____ Treatment Received: _____ _____ Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No First & Last Treatment Date: _____ Additional tests or treatment recommended? _____ Medication prescribed (if any): _____ _____ _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____



APPLICANT NAME _____ DATE _____

DEPENDENT NAME (if submitted separately) _____

G. PRESCRIPTION INFORMATION WITHIN LAST 12 MONTHS (Attach a separate sheet if necessary)

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
 (If Yes, provide additional information below)

Name of Individual: _____ Name of Medication: _____ Reason for Taking: _____ First & Last Treatment Date: _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____
Name of Individual: _____ Name of Medication: _____ Reason for Taking: _____ First & Last Treatment Date: _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____
Name of Individual: _____ Name of Medication: _____ Reason for Taking: _____ First & Last Treatment Date: _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____
Name of Individual: _____ Name of Medication: _____ Reason for Taking: _____ First & Last Treatment Date: _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____
Name of Individual: _____ Name of Medication: _____ Reason for Taking: _____ First & Last Treatment Date: _____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No Physician Name _____ Phone # (_____) _____ City & State _____

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. **All of the answers provided within this application are, to the best of my knowledge and belief, true and complete.**
3. 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.
4. I understand that if I intentionally omit, submit or give 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, submit, or give false information on or in relation to this application that I may face legal liability, including legal action based on fraud. For more information about the possible financial, medical, and legal consequences of intentionally giving false 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 in making its determination to extend coverage and in establishing the premium rate 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.
- A waiting period of up to 24 months for coverage of preexisting medical conditions may apply.
- 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 effectiveness 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").



APPLICANT NAME _____ DATE _____

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:** _____

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.

I HAVE HAD FULL OPPORTUNITY TO READ AND CONSIDER THIS FORM. I UNDERSTAND THAT, BY SIGNING THIS FORM, I AUTHORIZE THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION DESCRIBED IN THIS FORM.

 Primary Applicant 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) Date _____

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



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.)

