



ILLINOIS STANDARD HEALTH EMPLOYEE APPLICATION FOR SMALL EMPLOYERS

INSURER USE ONLY
Policy/Group No.
Section No.
Effective Date
New Hire Waiting Period

TO BE COMPLETED BY EMPLOYER		
REASON FOR ENROLLMENT (mark all that apply)		
New Enrollment	Special Enrollment	Employment Status
<input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire Date: _____ <input type="checkbox"/> Late Enrollee	<input type="checkbox"/> Adoption <input type="checkbox"/> Court Order <input type="checkbox"/> Dependent Addition Date: _____ <input type="checkbox"/> Divorce <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Loss of Coverage <input type="checkbox"/> Marriage <input type="checkbox"/> Newborn <input type="checkbox"/> Other: Date of Event: _____	<input type="checkbox"/> Active <input type="checkbox"/> Retiree Retirement Date: ____/____/____ <input type="checkbox"/> Illinois Continuation <input type="checkbox"/> COBRA <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Qualifying Event: _____ Start Date: ____/____/____ Projected End Date: ____/____/____

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: _____

A. EMPLOYER INFORMATION

Employer _____
 Address _____
 Phone # (____) _____

B. 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) _____

C. COVERAGE REQUESTED

	Medical	Plan Choice:
Employee	Y / N	_____
Spouse/Domestic partner	Y / N	_____
Child(ren)	Y / N	_____

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

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.



EMPLOYER NAME _____ EMPLOYEE NAME _____

D. 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:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Dental* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Vision* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Basic Life* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Dependent Life* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Voluntary Life* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Short-Term Disability* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> My dependent child(ren)
Long-Term Disability* for:	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse/domestic partner	<input type="checkbox"/> 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 Acknowledgment & Signature section on page 10 of this application.



EMPLOYER NAME _____ EMPLOYEE NAME _____

E. 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 the 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.

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

<p>1. Employee Name (Last, First, MI) _____ Social Security number _____ Date of Birth ____/____/____ Weight _____ lbs. Height _____ ft. in. Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male HMO only: Primary care physician _____ Physician ID _____</p>
<p>2. Spouse/Domestic partner Name (Last, First, MI) _____ Social Security number _____ Date of Birth ____/____/____ Weight _____ lbs. Height _____ ft. in. Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male HMO only: Primary care physician _____ Physician ID _____</p>
<p>3. Dependent Name (Last, First, MI) _____ Social Security number _____ Date of Birth ____/____/____ Weight _____ lbs. Height _____ ft. in. Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male Eligible Military Veteran*: <input type="checkbox"/> Yes <input type="checkbox"/> No HMO only: Primary care physician _____ Physician ID _____</p>
<p>4. Dependent Name (Last, First, MI) _____ Social Security number _____ Date of Birth ____/____/____ Weight _____ lbs. Height _____ ft. in. Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male Eligible Military Veteran*: <input type="checkbox"/> Yes <input type="checkbox"/> No HMO only: Primary care physician _____ Physician ID _____</p>
<p>5. Dependent Name (Last, First, MI) _____ Social Security number _____ Date of Birth ____/____/____ Weight _____ lbs. Height _____ ft. in. Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male Eligible Military Veteran*: <input type="checkbox"/> Yes <input type="checkbox"/> No HMO only: Primary care physician _____ Physician ID _____</p>
<p>6. Dependent Name (Last, First, MI) _____ Social Security number _____ Date of Birth ____/____/____ Weight _____ lbs. Height _____ ft. in. Gender : <input type="checkbox"/> Female <input type="checkbox"/> Male Eligible Military Veteran*: <input type="checkbox"/> Yes <input type="checkbox"/> No HMO only: Primary care physician _____ Physician ID _____</p>

* 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.



EMPLOYER NAME _____ EMPLOYEE NAME _____

F. 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.

Enrolling Individual(s): (Non-Medicare)	Insurer (Including policyholder name, insurer name & phone number)	Date of Coverage MM/DD/YYYY		Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	Type of Current/Prior Coverage (Check all that apply) <input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None
		From	To		
Employee:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None
Spouse/Domestic partner:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group Medical <input type="checkbox"/> Individual Medical <input type="checkbox"/> Dental <input type="checkbox"/> None

MEDICARE: If you or any family members listed on this application have Medicare coverage **Part A** **Part B** **Part D**, please complete the following information.

Enrolling Individual:	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Enrollment
Enrolling Individual:	Effective Date / /	Medicare Number (please include alpha prefix)	Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ESRD <input type="checkbox"/> Dual Enrollment



EMPLOYER NAME _____ EMPLOYEE NAME _____

G. 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 H below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or 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: Yes No
 Non Insulin Dependent Insulin Dependent Insulin Pump
- 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



EMPLOYER NAME _____ EMPLOYEE NAME _____

J. Mental or emotional disorder? Yes No

K. Seizures/epilepsy, paralysis, or any other disorder of the brain or nervous system? Yes No

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

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

IF YOU ANSWERED “YES” TO ANY OF THE QUESTIONS ABOVE, YOU MUST COMPLETE SECTION ‘H’ BELOW.

H. ADDITIONAL INFORMATION

Question Number: _____	Name of Individual: _____
Condition/Diagnosis: _____	Date Diagnosed (MM/YYYY): _____
Treatment Received: _____	

Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Last Treatment Date: _____
Surgery, additional tests or treatment recommended? _____	
Medication prescribed (if any): _____	
_____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No	



EMPLOYER NAME _____ EMPLOYEE NAME _____

<p>Question Number: _____ Name of Individual: _____</p> <p>Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____</p> <p>Treatment Received: _____</p> <p>Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Treatment Date: _____</p> <p>Surgery, additional tests or treatment recommended? _____</p> <p>Medication prescribed (if any): _____</p> <p>_____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Question Number: _____ Name of Individual: _____</p> <p>Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____</p> <p>Treatment Received: _____</p> <p>Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Treatment Date: _____</p> <p>Surgery, additional tests or treatment recommended? _____</p> <p>Medication prescribed (if any): _____</p> <p>_____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Question Number: _____ Name of Individual: _____</p> <p>Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____</p> <p>Treatment Received: _____</p> <p>Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Treatment Date: _____</p> <p>Surgery, additional tests or treatment recommended? _____</p> <p>Medication prescribed (if any): _____</p> <p>_____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Question Number: _____ Name of Individual: _____</p> <p>Condition/Diagnosis: _____ Date Diagnosed (MM/YYYY): _____</p> <p>Treatment Received: _____</p> <p>Treatment Ongoing? <input type="checkbox"/> Yes <input type="checkbox"/> No Last Treatment Date: _____</p> <p>Surgery, additional tests or treatment recommended? _____</p> <p>Medication prescribed (if any): _____</p> <p>_____ Currently taking medication? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>



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



EMPLOYER NAME _____ EMPLOYEE NAME _____

J. ADDITIONAL COVERAGE OPTIONS

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

	Employee	Spouse/Domestic partner	Child(ren)
Dental	Y / N <input type="checkbox"/> PPO <input type="checkbox"/> HMO Dental HMO Office ID #: <i>(If applicable)</i> _____	Y / N <input type="checkbox"/> PPO <input type="checkbox"/> HMO Dental HMO Office ID #: <i>(If applicable)</i> _____	Y / N <input type="checkbox"/> PPO <input type="checkbox"/> HMO Dental HMO Office ID #: <i>(If applicable)</i> _____
Vision	Y / N	Y / N	Y / N
Basic Life	Y / N	Y / N	Y / N
Dependent Life	Y / N	Y / N	Y / N
Voluntary Life	Y / N Amount <i>(if applicable)</i> : \$ _____	Y / N Amount <i>(if applicable)</i> : \$ _____	Y / N Amount <i>(if applicable)</i> : \$ _____
Short-Term Disability	Y / N	Y / N	Y / N
Long-Term Disability	Y / N	Y / N	Y / N

Employee Class (employer will provide you with this information if needed): _____

Salary (if requesting life or disability coverage):
 \$ _____ Hourly Weekly Monthly Semi-Monthly Annually

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 _____

K. ACKNOWLEDGMENT & 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.
- 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 C and Section J 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.