

## **TITLE 50: INSURANCE**

### **PART 2030 STANDARD HEALTH APPLICATIONS**

#### **CHAPTER 1: DEPARTMENT OF INSURANCE**

##### **Section 2030.10 Purpose**

The purpose of this Part is to implement Section 359b of the Illinois Insurance Code that, in part, provides for the creation of a standard health application to be used by all carriers offering health benefit plans in the small group market and individual health insurance coverage in the individual market. This Part establishes criteria and provides guidance to carriers for the use of the standard health applications. This Part also establishes criteria for use of the standard health applications electronically, as well as for their translation into other languages.

##### **Section 2030.20 Definitions**

The following definitions shall apply to this Part:

"Applicant" means, in connection with an application for a health benefit plan or health insurance coverage, any person requesting coverage, including, with respect to a small employer, the employer's individual employees and their dependents.

"Carrier" or "health insurance issuer" means any entity that provides health insurance in this State. For the purposes of this Part, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization, or any other entity providing a health benefit plan or health insurance coverage subject to State insurance regulation.

"Code" means the Illinois Insurance Code [215 ILCS 5].

"Department" means the Illinois Department of Insurance.

"Director" means the Director of the Illinois Department of Insurance.

"Health benefit plan" or "health plan" means any hospital or medical expense-incurred policy, hospital or medical service plan contract, or health maintenance organization subscriber contract. Health benefit plan shall not include individual, accident-only, credit, dental, vision, Medicare supplement, hospital indemnity, long term care, specific disease, stop loss or disability income insurance, coverage issued as a supplement to liability insurance, workers' compensation or similar insurance, or automobile medical payment insurance.

"Health insurance coverage", "individual health insurance coverage" and "individual market" shall have the meanings given the terms in the Illinois Health Insurance Portability and Accountability Act (Illinois HIPAA) [215 ILCS 97].

"Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employs at least 2 employees on the first day of the plan year.

Application of aggregation rule for small employers. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Internal Revenue Code of 1986 (26 USC 414(b)) shall be treated as one employer.

Employers not in existence in preceding year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year.

Predecessors. Any reference in this Part to a small employer shall include a reference to any predecessor of that employer.

"Small employer carrier" means a carrier that offers health benefit plans covering employees of one or more small employers in this State.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health benefit plan maintained by a small employer.

### **Section 2030.30 Illinois Standard Health Applications**

a) **Applicability.** All small employer carriers shall use a version of the Illinois Standard Health Employee Application for Small Employers (Appendix A), and shall not use any alternative application form, in connection with a small employer's application for a new health benefit plan. All carriers offering health insurance coverage in the individual market shall use a version of the Illinois Standard Health Application for Individual & Family Health Insurance Coverage (Appendix B), and shall not use any alternative application form, in connection with an application for new individual health insurance coverage. Carriers not subject to this Part may use the standard health applications on a voluntary basis, subject to the requirements of this Part.

b) **Filing and Use**

1) No version of the standard health application, including an unmodified version of Appendix A or Appendix B, may be used by a carrier until the application is filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916. Carriers may use a standard health application upon filing with the Department if the filing is accompanied by a properly completed and executed officer's Certification of Compliance (Appendix C). An application shall not be considered as filed with the Department until the carrier receives notice from the Department indicating that the filing has been received and entered in the Department's filing system.

2) Online versions of the standard health applications must be filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916. Filings shall include screen shots of every application page that an applicant could encounter when completing the online application, as well as a copy of a sample completed application as required by subsection (c)(1). Carriers may use online versions of the standard health application upon filing if the filing is accompanied by a properly completed and executed officer's Certification of Compliance (Appendix C). An application shall not be considered as filed with the Department until the carrier

receives notice from the Department indicating that the filing has been received and entered in the Department's filing system.

3) Versions of the standard health applications that have been translated into another language must be filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916. Carriers may use translated versions of the standard health applications upon filing if the filing is accompanied by:

- A) a properly completed and executed officer's Certification of Compliance (Appendix C); and
- B) documentation proving that the application is a certified translation and is contextually identical to Appendix A or Appendix B. An application shall not be considered as filed with the Department until the carrier receives notice from the Department indicating that the filing has been received and entered in the Department's filing system.

c) **Form and Content.** A standard health application filed pursuant to subsection (b) shall contain verbatim the text of Appendix A or Appendix B. A standard health application shall not vary from the format of Appendix A or Appendix B, including font size, use of bold character and underlining, line spacing, and the order of questions or sections within the application, except as provided in this subsection (c) and subsection (e)(1).

- 1) Online versions of the standard health applications may vary from the format of Appendix A or Appendix B to the extent the variation allows an applicant to more easily complete and submit the online application. An electronic copy of the completed online application shall be made available to applicants for printing or saving upon completion, and the electronic copy shall be substantially similar to the form and content of Appendix A or Appendix B.
- 2) In order to allow applicants to apply for coverage from multiple carriers using a single application, a standard health application filed pursuant to subsection (b) shall not contain logos, addresses, or other carrier-specific information or identifiers, except that the carrier's NAIC number shall appear in the bottom right hand corner of each page.
- 3) Instruction #4 on page 1 of Appendix 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 Appendix A or page 11 of Appendix B.
- 5) The format of a standard health application filed pursuant to subsection (b) of this Section may vary from the format of Appendix A or Appendix B in other ways at the discretion of the Director.

d) The Department will maintain a dedicated portion of its website to facilitate use of the standard health applications by both applicants and carriers. The website will also provide links to additional information about health insurance rights under State and federal law, as referenced throughout Appendix A and Appendix B, as well as an example of a properly completed question as referenced in Section F of Appendix B. PDF versions of the Illinois Standard Health Employee Application for Small Employers and the Illinois Standard Health Application for Individual & Family Health Insurance Coverage will be available for use or download from the Department's website. The PDF versions will allow applicants to complete and submit the standard health application to a carrier or carriers electronically, or to print the

application out and complete by hand. All carriers subject to this Part shall allow for the electronic submission of the standard health applications pursuant to a reasonable process established by the carrier and clearly set forth on the carrier's website.

e) The Illinois Standard Health Employee Application for Small Employers (Appendix A) shall be used by small employer carriers for underwriting and enrolling a new small employer group and for adding new enrollees to an existing small employer group health benefit plan. A carrier is not required to use the standard application when adding new enrollees to an existing small employer group health benefit plan if the carrier does not request information about the health status or health history of the individual employees or dependents to be added.

- 1) A small employer carrier that uses a separate enrollment form for adding new enrollees to an existing small employer group health benefit plan may modify the "To Be Completed by Employer" box of Appendix A as necessary.
- 2) Any such separate enrollment form for adding new enrollees to an existing small employer group health benefit plan must be filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916.

f) Reciprocity. All carriers subject to this Part shall implement policies and procedures necessary to use the standard health applications. Applicants for a health benefit plan in the small group market may complete any version of the Illinois Standard Health Employee Application for Small Employers (Appendix A) filed by any carrier pursuant to subsection (b), or the version available on the Department's website (as described in subsection (d)), and no small employer carrier may refuse to accept or may discriminate in the processing of that standard health application. Applicants for health insurance coverage in the individual market may complete any version of the Illinois Standard Health Application for Individual & Family Health Insurance Coverage (Appendix B) filed by any carrier pursuant to subsection (b), or the version available on the Department's website (as described in subsection (d)), and no carrier offering individual health insurance coverage may refuse to accept or may discriminate in the processing of that standard health application.

g) The information contained within a completed standard health application shall be considered current by the carrier for a minimum of 60 days from the date of the earliest signature. For the period of time that the information contained within a standard health application is considered current, carriers may not require an applicant to complete a new standard health application. However, carriers may require an applicant to certify that the information contained in the completed standard health application is current. A carrier shall accept and utilize information provided by an applicant subsequent to the date the applicant signed the completed application if the applicant is providing the carrier with additional or modified information.

#### **Section 2030.40 Administrative Sections**

a) Carriers subject to this Part 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 shall be filed with the Department in accordance with the filing procedures established by 50 Ill. Adm. Code 916, and shall be subject to the following requirements:

- 1) Administrative sections shall 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 shall constitute a separate and distinct section that may be detached from the standard health application. Administrative sections shall contain carrier-specific logos and addresses to distinguish those sections from the standard health applications.
  
  - 3.) Administrative sections shall comply with all applicable provisions of the Illinois Insurance Code and related laws and regulations.
  
  - 4) An administrative section need not be filed with the Department under this Section if the entire administrative section has been previously approved by the Department under a unique form filing number (and such approval remains in effect).
- b) Carriers may use administrative sections upon filing with the Department if the filing is accompanied by a properly completed and executed officer's Certification of Compliance (Appendix C).

**Section 2030.APPENDIX A Illinois Standard Health Employee Application for Small Employers**



**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: 2079 January 21, 2011 \_\_\_\_\_ 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	
<b>Special Enrollment:</b>	Adoption    Court Order    Dependent Addition    Divorce    Domestic Partner
Loss of Coverage    Marriage    Newborn    Other	Date of Event: ____/____/____
<b>Employment Status:</b>	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

<b>Medical</b>		
Employee: Yes    No	Spouse/Domestic Partner: Yes    No	Child(ren): Yes    No
Plan Choice:	Plan Choice:	Plan Choice:
If you are <b>waiving (declining)</b> coverage for yourself or any member of your family, you <u>must</u> complete Section C below.		

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

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):

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

<sup>V</sup> 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.

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

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](http://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:		
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:		

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

Employer Name \_\_\_\_\_ Employee Name \_\_\_\_\_

**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: \_\_\_\_\_

**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):

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

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
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

<b>2</b> Are you, your spouse/domestic partner, or any dependent for whom you are requesting coverage currently pregnant? Due Date: ____/____/____ (MM/DD/YYYY) If yes, are multiples (twins, triplets, etc.) expected? Are there any known complications, or is a cesarean section planned?	Yes	No
	Yes	No
	Yes	No
<b>3</b> <b>Within the past 12 months</b> , have you or your spouse/domestic partner used any tobacco products?	Employee: Yes	No
	Spouse/Domestic Partner: Yes	No
<b>4</b> <b>Within the past 12 months</b> , has any applicant been prescribed medication (other than for the common cold or flu) that is <b>not indicated elsewhere in this application</b> ?	Yes	No
<b>5</b> <b>Within the past 5 years</b> , 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 <b>any illness, injury or health condition not indicated above</b> ?	Yes	No

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

Employer Name \_\_\_\_\_ Employee Name \_\_\_\_\_

**G. Additional Information**

**If you answered “Yes” to any of the questions above, you must complete this section.**  
**If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.**

Question Number: \_\_\_\_\_ Name of Individual: \_\_\_\_\_

Condition/Diagnosis: \_\_\_\_\_ Date Diagnosed (MM/YYYY): \_\_\_\_\_

Treatment Received: \_\_\_\_\_

Treatment ongoing? Yes No Last Treatment Date: \_\_\_\_\_

Surgery, additional tests or treatment recommended? \_\_\_\_\_

Medication Prescribed (if any): \_\_\_\_\_

\_\_\_\_\_ Currently taking medication? Yes No

Question Number: \_\_\_\_\_ Name of Individual: \_\_\_\_\_

Condition/Diagnosis: \_\_\_\_\_ Date Diagnosed (MM/YYYY): \_\_\_\_\_

Treatment Received: \_\_\_\_\_

Treatment ongoing? Yes No Last Treatment Date: \_\_\_\_\_

Surgery, additional tests or treatment recommended? \_\_\_\_\_

Medication Prescribed (if any): \_\_\_\_\_

\_\_\_\_\_ Currently taking medication? Yes No

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

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

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

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 % \_\_\_\_\_

**ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER**

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.

---

**Section 2030.APPENDIX B Illinois Standard Health Application for Individual & Family Health Insurance Coverage**



**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](http://www.insurance.illinois.gov).

<b>A. Primary Applicant Information</b>			
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: <input type="checkbox"/> New Application <input type="checkbox"/> Dependent Addition <input type="checkbox"/> Plan Change <input type="checkbox"/> Reinstatement			
<b>Requested Effective Date:</b> 2079January 21, 2011_____ (Coverage not in force until the insurance carrier approves your application and determines the effective date.)			

<b>B. Employment Information</b>	
Occupation:	Job Title:
Spouse/Domestic Partner's Occupation:	Job Title:
Currently employed? (optional)    Self:    Yes    No    Spouse/Domestic Partner:    Yes    No	

**ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE**

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:

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: _____	

**ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE**

PRIMARY APPLICANT NAME \_\_\_\_\_ DATE \_\_\_\_\_

**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? <sup>v</sup>     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? <sup>v</sup>     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? <sup>v</sup> 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? <sup>v</sup> 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? <sup>v</sup> Yes No

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

<sup>v</sup> 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.

#### ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE

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](http://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<sup>v</sup> High/elevated cholesterol<sup>v</sup>

<sup>v</sup> 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

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.

ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE

PRIMARY APPLICANT NAME \_\_\_\_\_ DATE \_\_\_\_\_

DEPENDENT NAME (If submitted separately) \_\_\_\_\_

<b>Within the past FIVE (5) YEARS:</b>		
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	<b>Other than indicated elsewhere on this application</b> , 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 <b>waiting for results</b> , or been advised to have treatment, testing, counseling, therapy, or surgery which has <b>not yet been performed</b> ?	Yes No

<b>Within the past TWELVE (12) MONTHS:</b>		
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
<b>If yes, indicate:</b>		
Who & Which Activity	When/How Often	Do you plan continued participation?
_____		Yes No
_____		Yes No
_____		Yes No

8	<b>Other than indicated elsewhere on this application</b> , has any person applying for coverage <b>EVER</b> 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

**ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE**

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

**10 For EACH person applying for coverage, provide the following current 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](http://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 \_\_\_\_\_

#### ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE

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](http://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: \_\_\_\_\_

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 (2½) 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.

**ILLINOIS STANDARD HEALTH APPLICATION FOR INDIVIDUAL & FAMILY HEALTH INSURANCE COVERAGE**

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.)	

---

**Section 2030.APPENDIX C Certification of Compliance**

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 and Part 2030 of Title 50 of the Illinois Administrative 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.)

SOURCE: Adopted at 35 Ill. Reg. 2079, effective January 21, 2011.