



ILLINOIS STANDARD HEALTH APPLICATION – SMALL EMPLOYER

OFFICE USE ONLY
Policy / Group No. _____
Effective Date _____
PEC _____
New Hire Waiting Period _____

REASON FOR ENROLLMENT (mark all that apply)
<input type="checkbox"/> New Group <input type="checkbox"/> Newborn* <input type="checkbox"/> Loss of Coverage*
<input type="checkbox"/> Open Enrollment <input type="checkbox"/> Marriage* <input type="checkbox"/> Court Order*
<input type="checkbox"/> New Hire* <input type="checkbox"/> Divorce* <input type="checkbox"/> Other:
<input type="checkbox"/> New Application <input type="checkbox"/> Re-apply <input type="checkbox"/> Dependent Addition
* Date of Event _____
<input type="checkbox"/> COBRA / mini-COBRA / Alternative Coverage for:
<input type="checkbox"/> Employee <input type="checkbox"/> Dependent Employer Name: _____
Length of COBRA continuation coverage: <input type="checkbox"/> 18 mos. <input type="checkbox"/> 36 mos. Other: _____
Original Qualifying Event Date: _____ Qualifying Event Date: _____ Date of Event: _____

COVERAGE REQUESTED						
Coverage	Self	Spouse	Child(ren)	COBRA	mini-Cobra	Alternative Coverage
Medical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dental	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Address _____ Apt # _____ City _____ State _____ Zip _____

Home (or other) Phone (____) _____ Business Phone (____) _____

Email Address _____

C. ENROLLING EMPLOYEE / SPOUSE / DEPENDENTS (attach separate sheet if necessary)

In the section below, list yourself and all eligible family members to be included under coverage.

	Social Security # (for internal use only)	Name (Last, First, MI)	Date of Birth	Age	M/F	Weight	Height	Medical Coverage
Employee						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent						lbs.		<input type="checkbox"/> Yes <input type="checkbox"/> No

Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy. For information about Illinois' Young Adult Dependent Coverage law, please visit the Illinois Department of Insurance website at <http://www.insurance.illinois.gov>.



D. WAIVER OF COVERAGE

- Complete this section for yourself (if waiving) and/or any of your dependents for whom you are waiving coverage. You cannot enroll dependents if you are waiving coverage for yourself.
- If you decline enrollment for yourself and/or any of your dependents, including your spouse, because of other health care coverage, you may in the future be able to enroll the omitted individual(s) in this plan, provided that you request enrollment within 30 days after the other coverage of the individual(s) ends. ("Decline enrollment" includes omission of the individual from this application) In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption, the Special Enrollment Period.
- Please complete type of health care coverage for the employee and all eligible members who have other health care coverage by completing type of health care coverage, *i.e.* group, individual or other (Medicare, Medicaid, V.A., H.I.P., etc.).
- All eligible family members must be listed in this section or the ENROLLING EMPLOYEE / SPOUSE / DEPENDENTS section.

Persons waiving coverage. Include last name if different from employee. No nicknames, please.	Birth Date MM/DD/YYYY	Other Health Care Coverage	Type of Health Care Coverage			Insurer Name
			Group	Individual	Other (explain)	
Employee:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent:		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Dependent:		<input type="checkbox"/> Yes <input type="checkbox"/> No				

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.

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 Coverage (Check all that apply)
		From	To		
Employee:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Spouse:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical
Dependent:				<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Group <input type="checkbox"/> Individual <input type="checkbox"/> Dental <input type="checkbox"/> Medical

MEDICARE: If you or any family members listed on this application have Medicare, and is coverage Part A Part B Part D, please complete the following information. **Please submit a copy of your Medicare ID card with this application.**

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

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. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

F. DISABILITY INFORMATION

Are you or any dependent(s) disabled? Yes No If yes, indicate first and last name(s) _____

Reason for disability: _____

Is the disabled dependent unable to perform routine daily functions for two weeks or more? Yes No

Have you or any dependent(s) filed workers' compensation claims or disability claims within the last five years? Yes No

If so, what is the status of the claim(s)? _____



G. HEALTH STATEMENT

IF ANY OF THE BELOW CONDITIONS OR QUESTIONS ARE CHECKED “YES” PROVIDE DETAILS IN SECTIONS H. & I. ON THE FOLLOWING PAGE.

The federal Genetic Information Nondiscrimination Act prohibits health insurers from requesting, requiring, purchasing, or collecting “genetic information” for underwriting purposes. “Genetic Information” includes your genetic tests, the genetic tests of your family members, and the manifestation of a disease or disorder in family members not covered by this policy. Genetic information can also include requests for, or receipt of, genetic services, or participation in clinical research which includes genetic services. **Do not report genetic information on this form.** However, information about manifested diseases or conditions of anyone applying for coverage is not considered genetic information and is to be reported on this form, even if the disease or condition is caused by or associated with genetics.

EACH QUESTION MUST BE CHECKED “YES” OR “NO.” This health statement must be complete or the application will be returned. Inaccurate health information may result in the coverage being cancelled retroactively. It is your responsibility to notify the insurer of any change in health status while application is pending.

Respond to the following questions:		YES	NO		Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following (cont.):	YES	NO
1	Pregnancy / Adoption: Are you, your spouse, or any dependent family member pregnant or financially responsible for an unborn child, or do you anticipate adopting a child in the next 12 months?			21	Female Reproductive Conditions / Disorders: Irregular bleeding, abnormal Pap smear/test, endometriosis, recurring pelvic pain, pelvic inflammatory disease, or any other disorder of the reproductive system?		
2	Pregnancy / Fertility Related Treatment: Are you, your spouse, or any dependent family member being treated for infertility, fertility evaluation or treatment (including medication), miscarriage, complications related to pregnancy (including premature births)?			22	Digestive Conditions / Disorders: Ulcers, hernias, chronic diarrhea, diverticulitis, diverticulosis, irritable bowel syndrome, reflux, GERD, any other gallbladder or digestive disorder, hemorrhoids, polyps, or any other rectal disorder?		
3	Last Menstrual Period: Have you, your spouse or any eligible child (whether or not proposed for insurance) missed her last menstrual period? If yes, provide date of last menstrual cycle on the following page.			23	Nervous, Mental and Behavioral: Mental health counseling, psychotherapy, depression, stress, anxiety, attention deficit hyperactivity disorder (ADHD), mental health disorder, or chemical imbalance that required consultation or medication?		
Within the past 12 MONTHS has any applicant:		YES	NO	Within the past 10 YEARS has any applicant been diagnosed with or treated for any of the following:		YES	NO
4	Prescriptions / Medications / Immunizations: Been prescribed or taken any prescription or over-the-counter medications, drugs, or shots (including immunizations, birth control, etc.)?			24	Gout, arthritis, Rheumatoid arthritis, fibromyalgia, or scleroderma?		
5	Conditions Requiring Follow Up Medical Consult / Treatment: Do you, your spouse or any dependent family member have a condition for which hospitalization, tests, consultation, evaluation, surgery, or medication have been advised, but not completed?			25	Musculoskeletal Conditions / Disorders: Ankylosing spondylitis, neuropathy, osteogenesis imperfecta, osteoporosis, herniated and/or ruptured disc, spina bifida, kyphosis, scoliosis, spinal stenosis, spondylolisthesis, spondylolysis, or other musculoskeletal disorder?		
6	Medical Consult / Treatment: Consulted or received treatment from a doctor, chiropractor, counselor, therapist, or other health care provider, including routine & wellness care?			26	Digestive Conditions / Disorders: Crohn's disease, colitis, colostomy, ileostomy, or any other digestive disorder?		
7	Conditions Requiring Initial Medical Consult / Treatment: Had a health condition, problem, disorder, or any other medical or mental health conditions not listed for which medical or mental health advice or treatment has <u>not</u> been sought?			27	Alcohol or Drug Use / Abuse: been advised to reduce/limit alcohol use, or attended Alcoholics Anonymous (or similar program) for his/her own alcohol consumption, drug dependency, abuse or misuse of prescribed or non-prescribed drugs such as opiates, stimulants, depressants, and/or hallucinogens?		
Within the past 5 YEARS has any applicant been diagnosed with, treated for, or had any of the following:		YES	NO	28	Eating Disorders/ Obesity Treatment: including bulimia, anorexia, or obesity and any surgical services for obesity.		
8	Urinary, bladder, incontinence, kidney or liver conditions or disorders: Kidney stones, jaundice, nephritis, or any other disorder of the liver, kidneys or pancreas?			29	Respiratory Conditions / Disorders: RSV, reactive airway disease, tuberculosis, asthma, sleep apnea, pleurisy, COPD, sarcoidosis, or emphysema?		
9	Neurological Disorders: Recurring headaches, migraines, head injury, epilepsy, seizures, convulsions or other neurological disorder?			30	Tobacco use (chewing or smoking)? Quit Date: _____		
10	Metabolic and Endocrine Conditions / Disorders: Lupus, thyroid disorder, goiter, or any other lymph system disorder?			Has any applicant EVER been diagnosed with or treated for any of the following:		YES	NO
11	Eyes, ears, nose, sinus, or throat conditions / disorders or any other respiratory system disorder, including allergies or hay fever.			31	Birth Defects / Congenital Abnormalities: premature birth, development or learning disability, mental impairment, Down syndrome, or autism spectrum disorder?		
12	Skin Conditions / Disorders: Acne, psoriasis, eczema, growths (except warts), abnormal moles, abnormal birthmarks, or any other skin disorder?			32	Nervous, Mental and Behavioral: Bipolar affective disorder, manic depression, schizophrenia, chronic organic brain syndrome, or psychotic disorder?		
13	Breast Conditions / Disorders: Breast lumps, breast augmentation, or breast reduction?			33	Transplant or Implanted Device: Any organ or tissue transplant, pacemaker, or other implanted device?		
14	Heart Conditions / Disorders: Chest pain, high blood pressure, high cholesterol, irregular heart beat, or any other heart condition?			34	Heart and Circulatory Conditions / Disorders: Heart murmur, heart attack, bypass surgery, angioplasty/stent, blood clot, stroke, heart surgery, coronary artery disease, or congestive heart failure?		
15	Back, neck, bone, joint or spinal disorder: bone or joint disorders (including foot, knee, jaw, fracture, dislocation or joint replacement)?			35	Brain / Nervous System Conditions / Disorders: Multiple sclerosis, muscular dystrophy, cerebral palsy, Lou Gehrig's disease (ALS), Parkinson's disease, Alzheimer's disease, or dementia?		
16	Blood Conditions / Disorders: Hemophilia, anemia, blood, or bleeding disorder?			36	Diabetes (type I or II), insulin resistance?		
17	Male Reproductive Conditions / Disorders: Impotence, prostate or testicular disorder, abnormal PSA, or other reproductive disorder?			37	Immune System Conditions / Disorders: Immune system diseases, human immunodeficiency virus (HIV), acquired immune deficiency syndrome (AIDS), or AIDS related complex (ARC)?		
18	Circulatory System Conditions / Disorders: Varicose veins, or any other circulatory disorder?			38	Cancer / Tumors: (including skin cancer or melanoma) or tumors?		
19	Hospitalization / Surgery: Have you, your spouse, or any dependent family member been hospitalized or had surgery?			39	Urinary / Liver Conditions / Disorders: Cirrhosis, hepatitis, or renal failure?		
20	Sexually transmitted diseases?			OTHER MEDICAL INFORMATION		YES	NO
				40	Any medical condition or treatment that you are unsure of where it fits in above?		



J. ACKNOWLEDGMENT & SIGNATURE

I agree to abide by the insurer's enrollment provisions. I understand that coverage cannot start until after I have served the waiting period agreed to by the employer as recorded on the insurer's records. I authorize my employer to act as my agent in all matters of administration of the group program, and acknowledge that my employer is in no way acting as agent for the insurer.

I understand there may not be participating providers in all specialty fields.

I acknowledge that I have had the opportunity to enroll, but do not wish to make application for those individual(s) listed in the WAIVING OF COVERAGE section above (or any eligible family member not listed in the ENROLLING EMPLOYEE / SPOUSE / DEPENDENTS section above). In waiving coverage, I am aware that waiving members (including myself, if I am waiving) may not enroll until my group's anniversary, unless the waiving member qualifies for a Special Enrollment Period (SEP). If I have waived enrollment for myself or any of my dependents (including my spouse) because of other health care coverage or group health plan coverage, I may in the future be qualified for a SEP and be able to enroll the waived individual in this plan, provided I request enrollment within 30 days after the other coverage of the individual(s) ends due to loss of eligibility or an employer's ceasing to contribute toward that other coverage. In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I may be able to enroll myself and my dependents, provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

I understand that credit for prior coverage will be based upon the information contained in this application and/or proof of prior coverage, such as a Certificate of Creditable Coverage that I have obtained from my prior health care insurer(s) and provided to the insurer.

If any information provided is false or incomplete, the insurer may without advance notice pursue any remedies available under state or federal law, including but not limited to: declaring the coverage null and void and cancelling the coverage retroactive to its original effective date; or imposing the pre-existing condition waiting period and denying claims that are pre-existing, subject to credit for prior coverage.

If the policy contains a voluntary arbitration provision: ANY MATTER IN DISPUTE BETWEEN YOU AND THE INSURER MAY BE SUBJECT TO ARBITRATION AS AN ALTERNATIVE TO COURT ACTION PURSUANT TO THE RULES OF THE AMERICAN ARBITRATION ASSOCIATION OR OTHER RECOGNIZED ARBITRATOR, A COPY OF WHICH IS AVAILABLE ON REQUEST FROM THE INSURER, THE INSURER SHALL BEAR THE COSTS OF ARBITRATION, FILING FEES, ADMINISTRATIVE FEES AND ARBITRATOR FEES. OTHER EXPENSES OF ARBITRATION, INCLUDING, BUT NOT LIMITED TO: ATTORNEY FEES, EXPENSES OF DISCOVERY, WITNESSES, STENOGRAPHER, TRANSLATORS, AND SIMILAR EXPENSE, WILL BE BORNE BY THE PARTY INCURRING THOSE EXPENSES. ANY DECISION REACHED BY ARBITRATION SHALL BE BINDING UPON BOTH YOU AND THE COMPANY. THE ARBITRATION AWARD MAY INCLUDE ATTORNEY'S FEES, IF ALLOWED BY STATE LAW, AND MAY BE ENTERED AS A JUDGMENT IN ANY COURT OF PROPER JURISDICTION.

I further certify that all information completed on this form is true, correct and complete, and acknowledge my coverage may be subject to cancellation or other action permissible by law, if any completed information is found to be false or incorrect.

I attest that all information on this form is accurate. I have read the Acknowledgment of this document and agree to its terms. I have also completed an authorization to disclose protected health information form, if such form accompanies this application.

Employee Signature _____ Date _____
 (A faxed signature shall be valid as an original signature.)