



# ILLINOIS STANDARD HEALTH EMPLOYEE APPLICATION FOR SMALL EMPLOYERS

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

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

*This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies. The information you provide in this application will be sent to the following insurance companies:*

**(To be completed by employer)**

Insurer: \_\_\_\_\_ Insurer: \_\_\_\_\_ Insurer: \_\_\_\_\_  
 Insurer: \_\_\_\_\_ Insurer: \_\_\_\_\_ Insurer: \_\_\_\_\_

## A. EMPLOYER INFORMATION

Employer \_\_\_\_\_  
 Address \_\_\_\_\_  
 Phone # (\_\_\_\_) \_\_\_\_\_

## B. EMPLOYEE INFORMATION

Name (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_  
 Job Title \_\_\_\_\_ Hire Date \_\_\_\_\_ Hrs/ Week \_\_\_\_\_  
 Marital Status    Married    Single    Divorced    Widowed    Domestic Partner  
 Home Address \_\_\_\_\_ Apt # \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home (or Cell) Phone (\_\_\_\_) \_\_\_\_\_ Business Phone (\_\_\_\_) \_\_\_\_\_  
 Email Address (optional) \_\_\_\_\_

## C. COVERAGE REQUESTED

	Medical	Plan Choice:
Employee	Y / N	_____
Spouse/Domestic Partner	Y / N	_____
Child(ren)	Y / N	_____
If you are <b>waiving (declining)</b> coverage for yourself or any member of your family, you <u>must</u> complete Section D below.		

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.



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

**D. WAIVER OF COVERAGE**

*Please complete this section only if you are waiving (declining) coverage for yourself or one or more of your family members.*

I acknowledge that I have been given the opportunity to apply for group coverage available to me and my dependents through my employer.

I understand and agree:

- If I am declining coverage for myself, my spouse, or my dependent child(ren) because of other coverage, I may in the future be able to enroll myself, my spouse, or my dependent child(ren) provided that I request enrollment within 31 days after the other coverage ends.
- If I have a new spouse or child as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my new spouse 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 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 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	[ ] My Dependent Child(ren)
<b>Dental*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)
<b>Vision*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)
<b>Basic Life*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)
<b>Dependent Life*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)
<b>Voluntary Life*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)
<b>Short-Term Disability*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)
<b>Long-Term Disability*</b> for:	[ ] Myself	[ ] My spouse	[ ] My Dependent Child(ren)

\* If offered

I am **declining** group coverage for the following reason(s): (**check** all that apply):

- Spouse’s employer plan
- Individual coverage (non-group plan)
- COBRA/State Continuation
- Medicare or other Government Program
- Other (please explain): \_\_\_\_\_

**If you are declining ALL coverage for ALL persons, please skip to the Acknowledgment & Signature section on page 10 of this application.**



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

**E. INDIVIDUALS REQUESTING COVERAGE**

In the section below, 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. For information about Illinois' Young Adult Dependent Coverage law, which allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, please visit the Illinois Department of Insurance website at <http://www.insurance.illinois.gov>.

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

\* An "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, **and** who received a release or discharge other than a dishonorable discharge.

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



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

**F. CURRENT / PRIOR COVERAGE INFORMATION**

Please indicate for EACH person listed on this application any health coverage, including Medicare or Medicaid, in effect within 24 months prior to the proposed effective date of this coverage. Each person applying for coverage must be listed below. If no health care coverage was in effect within the past 24 months, please indicate **NONE**. If coverage is provided for a dependent from a previous marriage or relationship, please attach a copy of the court documentation showing who is responsible for the dependent(s)' health care coverage so that the insurer can determine whose coverage is primary.

**Note:** If you have had health care coverage within the last 63 days, your Pre-Existing Condition (PEC) waiting period limitation may be partially or completely waived. To determine if this applies to you, you must provide proof of prior coverage, such as a Certificate of Creditable Coverage from your previous insurer. Submission of prior coverage information does not automatically waive any PEC limitation. However, you will be subject to an automatic PEC Waiting Period of up to 12 months until we receive evidence of prior coverage.

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

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

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



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

**G. HEALTH STATEMENT****INSTRUCTIONS:**

1. Any information provided in this application is confidential.
2. The health information you provide below will be used by the insurance carrier to decide how much to charge your group for the coverage applied for. It will also be used by the insurance carrier to determine whether a Pre-Existing Condition Waiting Period(s) will apply to your coverage.
3. Each medical question below applies to all persons requesting coverage.
4. Answer the questions below with either Yes or No. If you answer Yes to any question, you must provide additional information in Section H below.
5. Do not leave any question unmarked.
6. Neither your employer nor your insurance agent can waive these requirements or may authorize you to provide anything less than a complete and accurate response to each of the questions.
7. You may receive a phone call from the insurance carrier after submitting this application. The purpose of this call is to obtain information needed to evaluate and help speed the processing of your application. Your answers will be strictly confidential.

1. For the following conditions, **within the past 5 years**, have you or any dependents for whom you are requesting coverage:

- Been tested for or diagnosed with;
- Had medical treatment recommended;
- Received medical treatment, including prescription medications; or
- Been hospitalized for any illness, injury, or health condition related to any of the categories listed below?

- A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels?  Yes  No
- B. Cancer or cancerous tumor?  Yes  No
- C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system?  Yes  No
- D. Diabetes? If yes, check all that apply:  Yes  No  
 Non Insulin Dependent  Insulin Dependent  Insulin Pump
- E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines?  Yes  No
- F. Growth disorder or a disorder of the pancreas?  Yes  No
- G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder?  Yes  No
- H. Reproductive organ disorders or infertility?  Yes  No
- I. Arthritis, or any other disorder of the joints, muscles, back, or bones?  Yes  No
- J. Mental or emotional disorder?  Yes  No



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

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

**L.** Lupus, or other disorder of the immune system?  Yes  No

**M.** Alcohol, drug, or substance use or dependency?  Yes  No

**2.** Are you, your spouse or any dependent for whom you are requesting coverage currently pregnant?  
 Yes  No Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ (MM/DD/YYYY)  
 If yes, are multiples (twins, triplets, etc.) expected?  Yes  No  
 Are there any known complications, or is a cesarean section planned?  Yes  No

**3. Within the past 12 months, have you or your spouse used any tobacco products?**  
 Employee:  Yes  No  
 Spouse:  Yes  No

**4. Within the past 12 months, has any applicant been prescribed medication (other than for the common cold or flu) that is not indicated elsewhere in this application?**  Yes  No

**5. Within the past 5 years, has any person applying for coverage been diagnosed or treated by a licensed medical professional for HIV, AIDS, or AIDS Related Complex?**  Yes  No

**6. Within the past 5 years, has any person applying for coverage been tested for or diagnosed with, had medical treatment recommended, received medical treatment, including prescription medications, or been hospitalized for any illness, injury or health condition not indicated above?**  Yes  No

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

**H. ADDITIONAL INFORMATION**

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



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

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



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

**J. ADDITIONAL COVERAGE OPTIONS**

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

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

**Employee Class** (employer will provide you with this information if needed): \_\_\_\_\_

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

**Beneficiary Information** (if requesting life insurance):

Primary Beneficiary Name (Last, First MI) \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_

Secondary Beneficiary Name (Last, First MI) \_\_\_\_\_  
 Relationship \_\_\_\_\_ Benefit % \_\_\_\_\_



EMPLOYER NAME \_\_\_\_\_ EMPLOYEE NAME \_\_\_\_\_

**K. ACKNOWLEDGMENT & SIGNATURE**

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I understand, agree and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section C and Section J of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

**Employee Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

For assistance in completing this application, please contact your employer or insurance agent. For information about your health care rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.