



Illinois Standard Health Employee Application

Complete this application to apply for group health insurance through your employer.

If you want help with this application, please call your employer or insurance agent.

For information about your health care rights, call the Office of Consumer Health Insurance at 877-527-9431 (TTY: xxx-xxx-xxxx). The call is free.

Employer information

Employer name:		Employer phone: ()	
Address:			
City:	State:	ZIP Code:	

Your employer will send your application to these insurance companies:

- | | | |
|--|--|--|
| <input type="checkbox"/> Insurance Company A | <input type="checkbox"/> Insurance Company C | <input type="checkbox"/> Insurance Company E |
| <input type="checkbox"/> Insurance Company B | <input type="checkbox"/> Insurance Company D | <input type="checkbox"/> Insurance Company F |

A Employee: tell us about you

Last name:		First name:		Middle initial:
Job title:		Date you were hired:	How many hours each week?	
Marital status: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic partner				
Home address:			Apartment number:	
City:	State:	ZIP Code:		
Home or cell phone: ()		Work phone: ()		
Email address (if you have one):				

B Who needs health insurance coverage?

Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse or domestic partner: <input type="checkbox"/> Yes <input type="checkbox"/> No	Child or children: <input type="checkbox"/> Yes <input type="checkbox"/> No
What plan?		

Applicant: please continue to the next page ▶

TO BE COMPLETED BY EMPLOYER: Reason for enrollment (check all that apply)

New enrollment	<input type="checkbox"/> New group <input type="checkbox"/> Open enrollment <input type="checkbox"/> New hire (date hired ____ / ____ / ____) <input type="checkbox"/> Late enrollee
Special enrollment	<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 ____ / ____ / ____
Employment status	<input type="checkbox"/> Active <input type="checkbox"/> Retiree (retirement date ____ / ____ / ____) <input type="checkbox"/> Illinois Continuation: <input type="radio"/> COBRA <input type="radio"/> Employee <input type="radio"/> Dependent Qualifying event _____ Start date ____ / ____ / ____ Projected end date ____ / ____ / ____

C If you do not want insurance coverage for yourself or a family member, complete this section.

I know that I may apply for group insurance coverage for me and my dependents through my employer.

I understand and agree with these statements:

- I know that I may apply for group insurance coverage for me and my dependents through my employer.
- If I do not want insurance now for me, my spouse, domestic partner or children, I may be able to get coverage in the future. To get coverage in the future I know that I must apply within 31 days after the coverage we have now ends.
- I may be able to get coverage for me and a new spouse, domestic partner or child if I apply within 31 days after getting the new spouse, domestic partner or child.
- If I apply for coverage in the future for any reason except that my coverage ended or I now have a new spouse, domestic partner or child, I know that I may have to wait for the next open enrollment period.
- If I apply for coverage in the future for any reason except that my coverage ended or I now have a new spouse, domestic partner or child, I know that I may be a “late enrollee.” If a late enrollee or anyone applying for coverage has a pre-existing condition (a chronic medical problem), that person may not be able to get coverage for up to 18 months.
- I was not pressured, forced, or unfairly persuaded by my employer or anyone from the insurance companies into declining group coverage.

I **do not** want coverage for these people:

Medical	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Dental (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Vision (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Basic life (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Dependent life (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Voluntary life (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Long-term disability (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children
Short-term disability (if offered)	<input type="checkbox"/> Myself	<input type="checkbox"/> My spouse or domestic partner	<input type="checkbox"/> My child or children

I, the employee, **do not** want health insurance coverage for these reasons (check all that apply):

- I already have insurance coverage through my spouse’s work
- I have individual coverage (it’s not a group plan)
- I have COBRA/State Continuation
- I am covered under Medicare or other Government Program
- Other (please explain): _____

🌟 If you want health insurance coverage, please complete pages 3 – 10.

If you do not want health insurance coverage, please skip to page 10 and sign the form.

D Tell us about the people who need insurance coverage.

Please list everyone who qualifies for coverage.

- If you are not sure who may qualify, ask your employer or an insurance agent.
- If you need information about the Illinois Young Dependent Coverage Law, which allows parents to cover children up to age 26 or up to age 30 (for military dependents), please visit this website: **www.insurance.illinois.gov**
- You may apply for “eligible military veterans” who are dependents. An “eligible military veteran” is someone who served in the active or reserved U.S. Armed Forces or the National Guard, *and* who was released or discharged, but not dishonorably discharged.

If you need more space, please attach a separate sheet and be sure to sign and date that sheet.

Employee

Last name:		First name:		Middle initial:
Social Security number:			Date of birth: ____ / ____ / ____	
Weight: lbs.	Height: ft.	in.	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
If you are in a health plan now, who is your Primary Care Physician? _____				
What is the Physician ID number? _____				

Spouse or domestic partner

Last name:		First name:		Middle initial:
Social Security number:			Date of birth: ____ / ____ / ____	
Weight: lbs.	Height: ft.	in.	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
If this person is in a health plan now, who is the Primary Care Physician? _____				
What is the Physician ID number? _____				

Dependent #1

Last name:		First name:		Middle initial:
Social Security number:			Date of birth: ____ / ____ / ____	
Weight: lbs.	Height: ft.	in.	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
If this person is in a health plan now, who is the Primary Care Physician? _____				
What is the Physician ID number? _____				

Dependent #2

Last name:		First name:		Middle initial:
Social Security number:			Date of birth: ____ / ____ / ____	
Weight: lbs.	Height: ft.	in.	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
If this person is in a health plan now, who is the Primary Care Physician? _____				
What is the Physician ID number? _____				

Dependent #3

Last name:		First name:		Middle initial:
Social Security number:			Date of birth: ____ / ____ / ____	
Weight: lbs.	Height: ft.	in.	Gender: <input type="checkbox"/> Female <input type="checkbox"/> Male	
If this person is in a health plan now, who is the Primary Care Physician? _____				
What is the Physician ID number? _____				

E Tell us about health insurance coverage.

Please tell us about any health insurance coverage in the last two years, including Medicaid.

- If you list a child from a previous marriage or relationship, you must attach a court paper showing who is responsible for the child's health insurance coverage.
- If you have a pre-existing condition (a chronic medical condition), you may not have to wait as long for coverage if you had insurance within the last 63 days. To find out, ask your previous insurance company for a "Certificate of Creditable Coverage." You will automatically have to wait for coverage for up to 12 months, or until we see the Certificate.

Employee

Last name:	First name:	Middle initial:
Have you had insurance in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? From ____ / ____ / ____ to ____ / ____ / ____ Will you keep this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type of coverage? <input type="checkbox"/> Group medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual medical <input type="checkbox"/> None	
Name of policy holder: _____		
Name of insurance company: _____ Phone: () _____		

Spouse or domestic partner

Last name:	First name:	Middle initial:
Has this person had insurance in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? From ____ / ____ / ____ to ____ / ____ / ____ Will this person keep this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type of coverage? <input type="checkbox"/> Group medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual medical <input type="checkbox"/> None	
Name of policy holder: _____		
Name of insurance company: _____ Phone: () _____		

Dependent #1

Last name:	First name:	Middle initial:
Has this person had insurance in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? From ____ / ____ / ____ to ____ / ____ / ____ Will this person keep this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type of coverage? <input type="checkbox"/> Group medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual medical <input type="checkbox"/> None	
Name of policy holder: _____		
Name of insurance company: _____ Phone: () _____		

Dependent #2

Last name:	First name:	Middle initial:
Has this person had insurance in the last 24 months? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? From ____ / ____ / ____ to ____ / ____ / ____ Will this person keep this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	What type of coverage? <input type="checkbox"/> Group medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual medical <input type="checkbox"/> None	
Name of policy holder: _____		
Name of insurance company: _____ Phone: () _____		

This section continues on the next page ▶

E Tell us about health insurance coverage.*(continued from the previous page)***Dependent #3**

Last name:

First name:

Middle initial:

Has this person had insurance in the last 24 months? Yes No

If yes, when? From ____ / ____ / ____ to ____ / ____ / ____

Will this person keep this coverage? Yes No

What type of coverage?

 Group medical Dental Individual medical None

Name of policy holder: _____

Name of insurance company: _____ Phone: () _____

Medicare: If you or anyone applying has Medicare, please answer these questions:**Who is applying?**

Last name:

First name:

Middle initial:

Which Medicare coverage does this person have? Part A Part B Part D

When did it start? ____ / ____ / ____

Reason for Medicare? _____

Medicare number? *(looks like this: 111-11-1111-A)*

____ - ____ - ____ - ____

Who is applying?

Last name:

First name:

Middle initial:

Which Medicare coverage does this person have? Part A Part B Part D

When did it start? ____ / ____ / ____

Reason for Medicare? _____

Medicare number? *(looks like this: 111-11-1111-A)*

____ - ____ - ____ - ____

F Tell us about the health of those who are applying.

Any information you give about your health or the health of your family will be kept private and confidential.

- The information here will help the insurance carrier decide how much to charge your group, and
- The information here will help the insurance carrier decide if you or any applicants have a pre-existing condition, and need to wait for coverage.
- You must answer these questions. No one, not even your employer or your insurance agent, has the authority to tell you not to answer.
- Your insurance carrier may call you to ask for more information after you complete this application. The answers you give will help speed up the application process. Your answers will be private and confidential.

1 Answer this question **for the last 5 years**. Have you or anyone who is applying had any sort of medical care, such as a test, a diagnosis, treatment or a recommendation for treatment, medicines, or hospitalization for any of these things?

- | | | |
|---|------------------------------|-----------------------------|
| A. Cardiovascular disease or heart attack, stroke, high blood pressure, or any other disease or disorder of the heart, arteries, blood, or blood vessels? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| B. Cancer or cancerous tumor? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| C. Asthma, emphysema, tuberculosis, or any other disorder of the lungs or respiratory system? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| D. Diabetes?
If yes, check all that apply: <input type="checkbox"/> Non insulin dependent <input type="checkbox"/> Insulin dependent <input type="checkbox"/> Insulin pump | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| E. Hepatitis, or any disorder of the liver, stomach, colon, or intestines? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| F. Growth disorder or a disorder of the pancreas? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| G. Chronic kidney stones, or other disorders of the kidney, prostate, or bladder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| H. Reproductive organ disorders or infertility? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| I. Arthritis, or any other disorder of the joints, muscles, back, or bones? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| J. Mental or emotional disorder? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| K. Seizures, epilepsy, paralysis, or any other disorder of the brain or nervous system? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| L. Lupus, or other disorder of the immune system? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| M. Alcohol, drug, or substance use or dependency | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- 2** Are you pregnant? Yes No If Yes, what is your due date? ____ / ____ / ____
- Is anyone else who is applying pregnant? Yes No If Yes, what is the due date? ____ / ____ / ____
- Is more than one baby expected? Yes No
- Is a Cesarean section planned, or are there other complications? Yes No

- 3** Have you or your spouse used any tobacco products **in the past 12 months**? Yes No

- 4** Has anyone who is applying used prescription medicine **in the last 12 months**? Yes No

- 5** Has anyone who is applying been diagnosed or treated for HIV, AIDS, or AIDS related complex **in the last 5 years**? Yes No

- 6** Has anyone who is applying been tested or treated for any other health problem **in the last 5 years**? Yes No

If you checked "Yes" to any questions above, go to Section G. If you answered "No" to all of the questions, go to Section H.

G If you answered “Yes” to any questions in Section F, please complete this section.

Which question in Section F is this about? _____ What is the person’s name? _____
What is the medical condition? _____
What date was it diagnosed? ____/____/____ Was the condition treated? Yes No
When was the last treatment? ____/____/____ Is the treatment still continuing? Yes No
Does this person need surgery or more treatment? Yes No
What medicine was prescribed? _____ Is the person still taking the medicine? Yes No

Which question in Section F is this about? _____ What is the person’s name? _____
What is the medical condition? _____
What date was it diagnosed? ____/____/____ Was the condition treated? Yes No
When was the last treatment? ____/____/____ Is the treatment still continuing? Yes No
Does this person need surgery or more treatment? Yes No
What medicine was prescribed? _____ Is the person still taking the medicine? Yes No

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What date was it diagnosed? ____/____/____ Was the condition treated? Yes No
When was the last treatment? ____/____/____ Is the treatment still continuing? Yes No
Does this person need surgery or more treatment? Yes No
What medicine was prescribed? _____ Is the person still taking the medicine? Yes No

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What medicine was prescribed? _____ Is the person still taking the medicine? Yes No

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What is the medical condition? _____
What date was it diagnosed? ____/____/____ Was the condition treated? Yes No
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What medicine was prescribed? _____ Is the person still taking the medicine? Yes No

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What is the medical condition? _____
What date was it diagnosed? ____/____/____ Was the condition treated? Yes No
When was the last treatment? ____/____/____ Is the treatment still continuing? Yes No
Does this person need surgery or more treatment? Yes No
What medicine was prescribed? _____ Is the person still taking the medicine? Yes No

H Tell us about other insurance coverage you want that your employer offers.

Complete this section only if you want any additional coverage offered by your employer, which is listed below.

Employee

Last name:

First name:

Middle initial:

▶ What kind of additional insurance (*check all that apply*):

Dental: Is this person in a PPO? Yes No

Is this person in an HMO? Yes No If yes, what is the HMO office ID number? _____

Vision **Basic life** **Dependent life** **Voluntary life:** How much? (*if applicable*) \$ _____

Short-term disability **Disability**

▶ What is your employee class (*your employer will provide this information if needed*): _____

▶ If you are asking for life or disability coverage, what is your salary?

\$ _____ Every hour Every week Two times a month Every month Every year

▶ If you are asking for life insurance coverage, what is the name of the beneficiary? _____

What is the relationship? (*for example, brother*) _____ What % of the benefit? _____

Spouse or domestic partner

Last name:

First name:

Middle initial:

▶ What kind of additional insurance (*check all that apply*):

Dental: Is this person in a PPO? Yes No

Is this person in an HMO? Yes No If yes, what is the HMO office ID number? _____

Vision **Basic life** **Dependent life** **Voluntary life:** How much? (*if applicable*) \$ _____

Short-term disability **Disability**

▶ What is this person's employee class (*the employer will provide this information if needed*): _____

▶ If this person is asking for life or disability coverage, what is their salary?

\$ _____ Every hour Every week Two times a month Every month Every year

▶ If this person is asking for life insurance coverage, what is the name of the beneficiary? _____

What is the relationship? (*for example, brother*) _____ What % of the benefit? _____

Dependent #1

Last name:

First name:

Middle initial:

▶ What kind of additional insurance (*check all that apply*):

Dental: Is this person in a PPO? Yes No

Is this person in an HMO? Yes No If yes, what is the HMO office ID number? _____

Vision **Basic life** **Dependent life** **Voluntary life:** How much? (*if applicable*) \$ _____

Short-term disability **Disability**

▶ What is this person's employee class (*the employer will provide this information if needed*): _____

▶ If this person is asking for life or disability coverage, what is their salary?

\$ _____ Every hour Every week Two times a month Every month Every year

▶ If this person is asking for life insurance coverage, what is the name of the beneficiary? _____

What is the relationship? (*for example, brother*) _____ What % of the benefit? _____

This section continues on the next page ▶

H Tell us about other insurance coverage you want that your employer offers.

(continued from the previous page)

Dependent #2

Last name:

First name:

Middle initial:

▶ What kind of additional insurance (check all that apply):

Dental: Is this person in a PPO? Yes No

Is this person in an HMO? Yes No If yes, what is the HMO office ID number? _____

Vision **Basic life** **Dependent life** **Voluntary life:** How much? (if applicable) \$ _____

Short-term disability **Disability**

▶ What is this person's employee class (the employer will provide this information if needed): _____

▶ If this person is asking for life or disability coverage, what is their salary?

\$ _____ Every hour Every week Two times a month Every month Every year

▶ If this person is asking for life insurance coverage, what is the name of the beneficiary? _____

What is the relationship? (for example, brother) _____ What % of the benefit? _____

Dependent #3

Last name:

First name:

Middle initial:

▶ What kind of additional insurance (check all that apply):

Dental: Is this person in a PPO? Yes No

Is this person in an HMO? Yes No If yes, what is the HMO office ID number? _____

Vision **Basic life** **Dependent life** **Voluntary life:** How much? (if applicable) \$ _____

Short-term disability **Disability**

▶ What is this person's employee class (the employer will provide this information if needed): _____

▶ If this person is asking for life or disability coverage, what is their salary?

\$ _____ Every hour Every week Two times a month Every month Every year

▶ If this person is asking for life insurance coverage, what is the name of the beneficiary? _____

What is the relationship? (for example, brother) _____ What % of the benefit? _____

H Please read this section and sign your name.

When I sign my name, it means that:

- I have read this document or someone read it to me.
- The answers I gave in this application are, to the best of my knowledge and belief, true and complete.
- I understand that no one has the authority to say that I do not need to answer any question, or decide if I can be covered, or choose my insurance company, change a contract, or change the insurance carrier's rights and responsibilities.
- I understand that the information I gave in this application, including the medical information for me, my spouse or domestic partner and my dependents, will be used by the insurance carrier to make decisions about whether we qualify.
- I understand that someone from the insurance company may call or write in the future to ask for my permission to give medical, claims or benefit information about me to xxxxxxxx xxxxxxx.
- If this application for coverage is accepted, coverage will start on the date that is on the insurance carrier's certificate of coverage or certificate of insurance.
- I give permission to the insurance carrier to send this information to xxxxxxx xxxxxxx electronically, using a computer.
- If I applied over the phone or on a computer, I did not sign the application myself. The insurance carrier checked my identity to verify it, and I gave my permission to the insurance carrier to print "Electronically Acknowledged" on the signature line. I agree that my electronic signature is a valid signature for all purposes.
- I understand that a photographic copy of this signature page will be considered as valid as the original.
- I am signing of my own free will.
- I intend to enroll for benefits in Section C and Section J of this application, for which I qualify now or may qualify soon under my employer's group contract(s).
- I give permission for my employer to make deductions for this coverage.
- I understand that if I change my mind and want to stop the coverage, I may do that by writing a letter to my employer telling him or her to stop making deductions.

Employee signature _____

Date _____

- ★ Keep a copy of this application for your own records.

For information about your health care rights under state and federal law, and to learn about other resources, please call the Illinois Department of Insurance's Office of Consumer Health Insurance at 877-527-9431. The call is free.

TO BE COMPLETED BY INSURER

Policy/Group No. _____

Section No. _____

Effective Date _____

New Hire Waiting Period _____