

# Blue Cross and Blue Shield of Illinois Cover Page to the Illinois Standard Health Employee Application for Small Employers

(Groups sized 1 - 150)

The purpose of this document is to help you – an employee requesting coverage from Blue Cross and Blue Shield of Illinois (BCBSIL) – fill out the new standard enrollment application created by the State of Illinois Department of Insurance.

As a result of the Illinois Insurance Fairness Act (Public Act 96-0857), the Illinois Department of Insurance created standard enrollment applications that must be used by all insurance companies doing business in the small group and individual markets.

The attached standard application goes into effect January 1, 2011 and replaces the small group enrollment applications previously used by insurance companies.

Although all insurance companies must use this standard enrollment application, the business needs and practices of all insurance companies are not the same. Not all the information requested on the new standard enrollment application is required by BCBSIL. However, there is information BCBSIL needs for the enrollment process that is not on the standard enrollment application.

The number of employees enrolling for coverage in an employer group will affect which parts of this application an individual employee will need to fill out. If you are unsure which category you fall into, please ask your group administrator.

For employers with 1-50 employees enrolling (defined by the Affordable Care Act as Small Group), employees should fill out sections A, B, C, D (partial), H and I. See detailed instructions below.

For employers with 51-150 employees (defined by the Affordable Care Act as Large Group regardless of the number enrolling), employees should fill out sections A, B, C, D, H and I. See detailed instructions below.

For employers with 51-150 employees (defined by the Affordable Care Act as Large Group regardless of the number enrolling) who wish to be medically underwritten, employees should fill out Sections A, B, C, D, E, F, G, H, and I. See detailed instructions below.

## 1. Employer Information

Your employer can use the Illinois Standard Health Employee Application with one or more insurance companies to request quotes for employee health insurance. This standard enrollment application means you do not need to fill out different applications from each insurance company. For your benefit, space is provided on the standard enrollment application so your employer can list the different insurance companies that will receive your health information.

You will see references to “spouse/party to a civil union/domestic partner” and “retiree” in the standard enrollment application. Domestic partners and retirees are eligible only if your employer chooses to cover them. Check with your employer if you are not sure.

## 2. Section B – Coverage Requested

Choose the type of health coverage/product you want based on the option(s) your employer has offered you.

- Some employers may offer only one type of coverage such as a PPO health benefit plan.
- Others may provide different options such as a PPO, an HMO, and/or a plan that includes a Health Savings Account (HSA) and/or a Health Care Account (HCA).
- You and your dependents (spouse/party to a civil union/domestic partner and children) will all be enrolled in the same product. You cannot pick different products for each person.

BCBSIL offers the following products for small group business. If you are not sure which product(s) are available to you, please ask your employer.

PPO	HMO	HSA	HCA
<ul style="list-style-type: none"> <li>• BlueAdvantage<sup>SM</sup> Entrepreneur PPO</li> <li>• BluePrint PPO</li> <li>• BlueChoice Select<sup>®</sup></li> <li>• BlueChoice Select<sup>®</sup> Value Choice</li> <li>• PPO Value Choice</li> <li>• CPO</li> <li>• CPO Value Choice</li> </ul>	<ul style="list-style-type: none"> <li>• BlueAdvantage<sup>SM</sup> HMO</li> <li>• HMO Value Choice</li> </ul>	<ul style="list-style-type: none"> <li>• BlueEdge<sup>SM</sup> HSA</li> <li>• BlueEdge<sup>SM</sup> Select HSA</li> </ul>	<ul style="list-style-type: none"> <li>• BlueEdge<sup>SM</sup> Direct HCA</li> </ul>



### 3. Section C – Waiver of Coverage

You may enroll yourself and your dependents (spouse/party to a civil union/domestic partner and children) in any coverage that your employer makes available to you, and that BCBSIL offers, except for Child Only policies. For Child Only policies, only the employee who meets the eligibility requirements may enroll. While the standard enrollment application may appear to suggest that you can waive enrolling yourself for coverage but still enroll your dependents, BCBSIL's policy requires that you (the employee) enroll in order to also enroll your dependents. If you choose to waive any coverage, your dependents cannot enroll in that coverage. However, you can enroll yourself in a coverage and choose to waive it for any of your dependents.

Please use this section to indicate if you do not wish to enroll yourself and/or any of your dependents in the following types of coverage:

- Medical
- Dental
- Basic Life
- Dependent Life
- Short-Term Disability (*BCBSIL offers only to employees*)
- Voluntary Life (*BCBSIL offers only to employees*)

While you may see these types of coverage on the standard application, they are not available from BCBSIL for small group business:

- Vision, except for pediatric vision services as described in the member booklet
- Long-Term Disability

For small group business, BCBSIL does not consider “*Individual Coverage*” (the second option on the standard application) as a valid reason to decline your employer-offered coverage.

### 4. Section D – Individuals Requesting Coverage

- **Weight and Height (for employers with 51-150 enrolling employees only)** - BCBSIL requires the weight and height for yourself and your spouse/party to a civil union/domestic partner. BCBSIL also requests weight and height be provided for any dependent that is 18 or older.
- **Military Veteran Dependents** - If you have dependents that are military veterans, you must include their honorable discharge documentation (Form DD-214).
- **Disabled Dependents** - Medical certification must be provided for disabled dependents.
- **HMO Coverage** - If you have elected to enroll in HMO coverage, information about your Primary Care Physician (PCP) is needed. The standard enrollment application provides space for your PCP and his or her identification number. However, BCBSIL requires more information about your physician. To accommodate this, a separate *HMO / CPO Provider Selection Enrollment and Change Form* is also required for HMO enrollees. This form is used to collect the following information:
  - Independent Practice Association (IPA) / Medical Group Number – this is required for BCBSIL to correctly identify the location you have chosen to access care from your PCP.
  - PCP name and the identification number.
  - Female enrollees may also choose a Woman's Principal Health Care Provider (WPHCP), so there is space to list this provider's name and identification number as well.
- **CPO Coverage** - BCBSIL offers a Community Participating Option (CPO) health benefit plan. This is similar to a PPO health benefit plan, but the member can gain greater savings by using providers at specific hospitals in the CPO network. Therefore, if you have chosen the CPO product, please use the *HMO / CPO Provider Selection Enrollment and Change Form* to indicate the number of the CPO network you have selected.

### 5. Section E – Current / Prior Coverage Information: Medicare

For small group business, “Dual Enrollment” is not an applicable Medicare entitlement reason for BCBSIL.

### 6. Sections F & G – Health Statement / Additional Information

**This section should be completed by employees of groups that have 51-150 enrolling employees and wish to be individually medically underwritten. If you are not sure about completing this section, check with your employer.**

- For health coverage, BCBSIL does not require the health statement questions to be completed by employees of groups that have more than 50 employees enrolling.
- For basic life coverage, the health statement questions must be completed by the employee if the group has two or more eligible employees AND is applying for an amount over the guarantee issue, applying for voluntary life coverage or for any late enrollment.
- Two pages are left blank so that information in these sections can be pulled out for underwriting (if applicable).

### 7. Section H – Additional Coverage Options

As stated in item #3, the following types of coverage are not available from BCBSIL for small group business:

- Vision, except for pediatric vision services as described in the member booklet
- Long-Term Disability



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

<b>TO BE COMPLETED BY EMPLOYER</b>	
Employer Name:	Phone #:
Address:	
<b>Reason for Enrollment</b> (Mark all that apply)	
<b>New Enrollment:</b> <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire (Date: _____) <input type="checkbox"/> Late Enrollee	
<b>Special Enrollment:</b> <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: _____/_____/_____	
<b>Employment Status:</b> <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 _____/_____/_____	

<b>A Employee Information</b>		
Name (Last)	(First)	(MI)
Job Title:	Hire Date:	Hrs/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:		Apt #:
City:	State:	Zip:
Home (or Cell) Phone: (        )	Business Phone: (        )	
Email Address (optional):		

<b>B Coverage Requested</b>		
<b>Medical</b>		
Employee: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse/Domestic Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No	Child(ren): <input type="checkbox"/> Yes <input type="checkbox"/> 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.		



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

\* If offered.

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

- Spouse/Domestic Partner’s Employer Plan
- Individual Coverage (Non-Group Plan)
- COBRA/State Continuation
- Medicare or other Government Program
- Other (please explain): \_\_\_\_\_

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



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.

<b>Employee Name</b> (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth:     /     /	
Weight: _____ lbs.	Height: _____ ft.   in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>HMO only</b> (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
<b>Spouse/Domestic Partner Name</b> (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth:     /     /	
Weight: _____ lbs.	Height: _____ ft.   in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>HMO only</b> (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth:     /     /	
Weight: _____ lbs.	Height: _____ ft.   in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>HMO only</b> (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth:     /     /	
Weight: _____ lbs.	Height: _____ ft.   in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>HMO only</b> (if/when applicable): Primary Care Physician: _____		Physician ID: _____	
<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____			
Social Security Number: _____		Date of Birth:     /     /	
Weight: _____ lbs.	Height: _____ ft.   in.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>HMO only</b> (if/when applicable): Primary Care Physician: _____		Physician ID: _____	



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

<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____	
Social Security Number: _____	Date of Birth:     /     /
Weight:               lbs.	Height:             ft.     in.
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Eligible Military Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>HMO only</b> (if/when applicable): Primary Care Physician: _____ Physician ID: _____	

**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.**

<b>Employee Name</b> (Last) _____ (First) _____ (MI) _____	
▶ <b>Current/Most Recent Coverage:</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ <b>Prior Coverage (if any):</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
<b>Spouse/Domestic Partner Name</b> (Last) _____ (First) _____ (MI) _____	
▶ <b>Current/Most Recent Coverage:</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ <b>Prior Coverage (if any):</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____	
▶ <b>Current/Most Recent Coverage:</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ <b>Prior Coverage (if any):</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None	
Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____	
Policyholder Name: _____ Insurer Name: _____	



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

<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____	
▶ <b>Current/Most Recent Coverage:</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ <b>Prior Coverage (if any):</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____	
<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____	
▶ <b>Current/Most Recent Coverage:</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ <b>Prior Coverage (if any):</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____	
<b>Dependent Name</b> (Last) _____ (First) _____ (MI) _____	
▶ <b>Current/Most Recent Coverage:</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____	
▶ Will the individual continue this coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No	
▶ <b>Prior Coverage (if any):</b> <input type="checkbox"/> Group Medical <input type="checkbox"/> Dental <input type="checkbox"/> Individual Medical <input type="checkbox"/> None Dates of Coverage: From: _____/_____/_____ To: _____/_____/_____ Policyholder Name: _____ Insurer Name: _____	
<p><b>Medicare:</b> If you or any family members listed on this application have Medicare coverage, please complete the following information.</p>	
<b>Enrolling Individual Name</b> (Last) _____ (First) _____ (MI) _____	
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D Effective Date: _____/_____/_____ Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ERSD <input type="checkbox"/> Dual Enrollment	Medicare Number (please include alpha prefix): _____
<b>Enrolling Individual Name</b> (Last) _____ (First) _____ (MI) _____	
Medicare <input type="checkbox"/> Part A <input type="checkbox"/> Part B <input type="checkbox"/> Part D Effective Date: _____/_____/_____ Reason for Medicare Entitlement: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> ERSD <input type="checkbox"/> Dual Enrollment	Medicare Number (please include alpha prefix): _____

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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:  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

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



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

L. HIV positive, AIDS, diseases associated with AIDS, 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
N. Organ or bone marrow transplant?	<input type="checkbox"/> Yes	<input type="checkbox"/> 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?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>3</b> Within the past 12 months, have you or your spouse/domestic partner used any tobacco products? Employee: Spouse/Domestic Partner:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>4</b> Within the past 12 months, has any applicant been prescribed medication (other than for the common cold or flu) that is <b>not indicated elsewhere in this application</b> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>5</b> 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 <b>any illness, injury or health condition not indicated above</b> ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>G Additional Information</b>
<b>If you answered "Yes" to <u>any</u> of the questions above, you must complete this section.</b>
<b>If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.</b>
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
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 \_\_\_\_\_

<b>Question Number:</b> _____ <b>Name of Individual:</b> _____ 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
<b>Question Number:</b> _____ <b>Name of Individual:</b> _____ 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
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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 % \_\_\_\_\_



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.