



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: _____

TO BE COMPLETED BY EMPLOYER	
Employer Name:	Phone #:
Address:	
Reason for Enrollment (Mark all that apply)	
New Enrollment: <input type="checkbox"/> New Group <input type="checkbox"/> Open Enrollment <input type="checkbox"/> New Hire (Date: _____) <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="checkbox"/> COBRA <input type="checkbox"/> Employee <input type="checkbox"/> Dependent Qualifying Event: _____ Start Date ____/____/____ Projected End Date ____/____/____	

A Employee Information		
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 Coverage Requested		
Medical		
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 waiving (declining) coverage for yourself or any member of your family, you <u>must</u> complete Section C below.		



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.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

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

Employee Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: Male Female

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Spouse/Domestic Partner Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: Male Female

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: Male FemaleEligible Military Veteran: Yes No

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: Male FemaleEligible Military Veteran: Yes No

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____

Dependent Name (Last) _____ (First) _____ (MI) _____

Social Security Number: _____

Date of Birth: / /

Weight: lbs. Height: ft. in. Gender: Male FemaleEligible Military Veteran: Yes No

HMO only (if/when applicable): Primary Care Physician: _____ Physician ID: _____



Employer Name _____ Employee Name _____

H Additional Coverage OptionsYou 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.

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